PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN HENTY HOUSE, LAUNCESTON ON TUESDAY 12 DECEMBER 2017

ACUTE HEALTH SERVICES IN TASMANIA

Ms ANN MAREE KEENAN, DEPUTY CEO/CHIEF NURSE, **Ms NICOLE BRADY**, DIRECTOR, STRATEGY AND IMPLEMENTATION, SAFER CARE VICTORIA, VIA TELECOMFERENCE, WERE CALLED AND EXAMINED.

CHAIR (Mr Valentine) - Welcome. All evidence we are taking this morning is being recorded on *Hansard*. It is to be part of the record of the inquiry and will be put up on our website. If at any point, during the hearing you feel there is something you wish to say that should be in confidence, we can talk about that go from there. If you feel there is something you wish to say that you do not want on the public record, please help us out by mentioning that and we can talk about that and the committee can have a discussion and we will go from there. Is that clear?

Ms KEENAN - Yes.

CHAIR - You would have received a copy of information for witnesses and have you read that?

Ms KEENAN - Yes, we have.

CHAIR - You do not have any issues there?

Ms KEENAN - No.

CHAIR - Given we have requested you to come in, we will give you the opportunity to provide an overview as to exactly what Safer Care Victoria and how it came about and then we can ask some questions following that. Is that okay with you?

Ms KEENAN - Yes, that is fine. We have prepared some information, which we are happy to go through and then give you the opportunity to ask us some questions along the lines of what you have described.

Thank you for the opportunity to present this morning to the subcommittee. We acknowledge the inquiry chair, the honourable Rob Valentine and other members of the inquiry. We also acknowledge the traditional owners of the land on which we meet today and pay our respects to elders, past and present, and to welcome any elders and Aboriginal people who may be here with us today.

I am Ann Maree Keenan, the Deputy Chief Executive Officer of Safer Care Victoria. I also hold the position of Chief Nurse and Midwifery Officer for Victoria. My colleague, Nicole Brady, is the Director of Strategy and Implementation. Nicole is joining me on the conference call today. Nicole will discuss the grounds that led to the Targeting Zero risk report, and the response of the Victorian Government to the report recommendations. I will discuss the functions, role and priorities of Safer Care Victoria and provide an overview of the work to date.

Safer Care Victoria has been invited by the subcommittee to discuss quality and safety in the Victorian Health Services and responses of the Victorian Government to improve quality and safety in the Victorian hospital system. Safer Care Victoria was established by the Andrews Government in January 2017 as a lead agency for quality and safety in Victoria. Safer Care Victoria was established following a recommendation contained in the report led by Dr Stephen Duckett, titled 'Targeting Zero', supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. We will discuss the Targeting Zero report in more detail later in this statement.

The mission of Safer Care Victoria is to enable all health services to deliver safe, high quality care and experiences for patients, carers and staff, and to ensure outstanding house care for all Victorians always. We do this by monitoring the standards of care provided and partnering with patients, clinicians and health service managers to support the continuous improvement of healthcare.

Before I hand over to Nicole, I thought I would give a bit of context around Victoria.

Victoria in the 2017 census described a population of just over 6.2 million people. The Australian Bureau of Statistics estimated that 4.7 million of Victorians live in greater Melbourne, and 1.4 million in regional and rural Victoria.

Victoria has 85 public health services and 84 registered private hospitals. Our 85 public hospitals operate on a devolved governance model, and each health service has an independent board and executive team. Prior to the Targeting Zero review and the establishment of Safer Victoria, the responsibility for monitoring and supporting quality and safety in our hospitals was largely housed in the Department of Health and Human Services branch, titled Health Performance and Commissioning.

That gives a bit of context as to the state of Victorian health services and where we have come from. I will now hand over to Nicole to give you the background as to the establishment of Safer Care Victoria.

CHAIR - Thank you.

Ms BRADY - Hello, it is Nicole Brady speaking. Thank you for the opportunity to share our background information and learnings with Tasmania. We are very happy to assist in any way we can to share anything we can to support you in your work in regards to any documentation or reports, or any of the other work that we have done.

Going back two years, in 2015, it emerged that a cluster of preventable perinatal mortalities, or in laymen's terms, stillbirths, had occurred at a mid-sized regional hospital in Victoria. Dr Stephen Duckett was commissioned to lead a review into what needed to be done in Victoria to ensure that such a tragedy would not occur again.

The final report Targeting Zero, which Ann Maree has already referred to, had 179 recommendations. Released in October 2016, the Government gave in-principle support to implementing all the recommendations. The essential theme of the report was not command and control of Victoria's devolved governance system, in which each of our 85 health services has

their own boards and CEOs; the report called for Government to do more to strengthen and support this system of devolved governance and our health services.

There were four main reform themes in the Targeting Zero report, each with an entity attached, or the establishment of a new entity. Quality and safety leadership was a very central theme to the report. The recommendations related to that theme called for the establishment of Safer Care Victoria. Another strong theme was the need for clinician engagement; the need to make sure that frontline experience and knowledge filtered through in terms of department policy and planning. The establishment of the Victorian Clinical Council was how that theme was addressed. Governance was also a key theme. More needed to be done to ensure that we had people with the right skills sitting on boards across the state. To support that we have established the board ministerial advisory committee. The final key theme of the Targeting Zero report was the need for much better data and information. The Victorian Agency for Health Information was established at the same time as Safer Care Victoria.

I will now talk to you about how we have gone about establishing Safer Care Victoria. The inaugural CEO is Professor Euan Wallace, a leading obstetrician with more than 20 years experience as a senior clinician and director of service at Monash Health, which is one of Victoria's biggest hospitals. He was appointed when the government response to the report was released in October 2016. Safer Care Victoria officially opened for business on 2 January 2017. The agency absorbed the staff and functions from the Health and Human Services, but Targeting Zero was very clear: we needed to recruit to boost numbers and bring clinical expertise and consumer advocacy into the forefront of Victoria's quality and safety workforce. This has occurred and Ann Maree will elaborate a little bit later on the roles of our chief clinicians at Safer Care Victoria.

Of the 179 recommendations in the Targeting Zero report, Safer Care Victoria inherited 73. Then we had to ask ourselves where to start and how to set our priorities in regard to implementation. We embarked on a lengthy engagement process. Our CEO, Euan Wallace, has travelled the state and in the first 11 months since we stood up as a new agency has met with each of the 86 health service CEOs, many of the boards, and visited many of our hospitals across the state. We have also held sector consultation sessions and worked internally with our staff.

Based on these consultations, the recommendations in the report and other inquiries, such as inquiries by the Victorian Auditor-General, we set five priorities for Safer Care Victoria to focus and provide stewardship to the sector in regard to the following:

- Partnering with consumers, which involves working with people to truly achieve patient-centred care across our health services.

- Partnering with clinicians, working with the people who provide the care and listening to their experience to inform system planning and policy and program design.

We are also focused on leadership and culture in our services, as the evidence shows the best organisations have healthy workplace culture and strong leaders.

Our fourth priority is system stewardship and support, which relates to the analysis and sharing of data and information. This involves us working closely with the Victorian Agency for Health Information.

Our final priority is innovation and improvement. The goal being here is to identify, lead and share best practice in quality and safety.

With the priorities established we then needed to ensure our organisation was structured in the right manner to deliver on them. This involved a restructure and more staff consultations, all leading up to a machinery of government change to establish Safer Care Victoria as an administrative office on 1 July 2017. This involves all of our staff being transitioned from the Department of Health and Human Services to Safer Care Victoria.

Our people are public servants but they are no longer employees of the department. It is a significant and symbolic change that signifies the new customer-oriented way our agency works with the sector. We are there to support health services deliver safe, high quality care. When things go wrong, our message out to people is, 'If we see a problem here, how can we help you address it?'. I will now hand back to Ann Maree to talk about our work in more detail.

Ms KEENAN - Thanks, Nicole. It is Ann Maree talking now. As Nicole stated, Safer Care Victoria is led by a clinician - a senior obstetrician, Professor Euan Wallace. We have three chief clinical officers. My position is the chief nurse and midwifery officer. We have a chief medical officer who is part-time and that is Associate Professor Andrew Wilson, who also works clinically as a cardiologist both in the public and the private sector. We have a chief paramedic officer, Alan Eade, who works two days a week with us and three days a week with Ambulance Victoria. We do have plans to recruit a chief allied health officer and that will happen at a future stage.

Our role as chief clinical officers is to provide clinical leadership to the sector and provide clinical advice to the Department of Health and Human Services, the Minister for Health and across all of the priority areas of Safer Care Victoria.

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. Undertaking sector-wide consultation on partnering with consumers literally inform a partnering with consumer framework for the state. 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.

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. Safer Care Victoria has recently commenced attending the performance meetings to provide that oversight of quality and safety to ensure that is prioritised on the same level as physical and activity performance. Quality and safety measures are included in the statement of priority that are signed off between the health service board chairs and the minister for Health.

We've restructured our clinical network to share resources and learning across disciplines. We've released a clinical engagement framework and the objectives of our clinical engagement for SCV are as follows:

> Safer Care Victoria staff will build strong and trusted relationships with a broad range of clinicians from across the state.
>
> Clinicians will have timely access to information that is meaningful to them and that helps them improve and innovate the care they provide.
>
> Clinicians from diverse backgrounds are involved and inspired to drive local and system level improvement and innovation.
>
> Safer Care Victoria staff receives advice that is expert, evidence-based and representative.
>
> Clinicians know that their opinions and expertise are valued by Safer Care Victoria.

We currently have nine clinical networks. They are: cardiac care; care of the older person; critical care; emergency care; maternity and newborn care; paediatrics; palliative care; renal care; and stroke care. We're in the process of forming a mental health clinical network.

As Nicole has already described, we've established the Victorian Clinical Council. This is a multi-disciplinary group of 72 people, including clinicians and consumers. The Clinical Council provides an important forum for a multi-disciplinary group of clinicians and consumers to provide collective clinical leadership and strategic advice on the delivery of high quality health care to improve health outcomes for all Victorians.

Another example of Safer Care Victoria's efforts to achieve the goal of zero avoidable harm is to improve the way we respond and learn from events across our health system. The agency is refreshing and invigorating the Victorian central event program, which aims to reduce the frequency of serious outburst events and improve patient safety across the state. This has been supported through the development of a new academy and clinical experts trained in incident investigation, human factors and systems-based needs.

We are also ensuring that we are visiting hospitals and building on relationships. This has been key to engaging with clinicians and executives and has led to an increased profile of Safer Care Victoria and requests to conduct systems safety assessments. We have conducted a number of systems-based assessments in multiple health services. These sorts of reviews range from service model assessments to entire department and health service assessments. These assessments have been requested often through the chief health officer, health services, the Department of Health and Human Services and the Minister for Health.

That is the end of our formal presentation of the information we thought we would share with you. It provides an overview of the work we have started on in this, our inaugural year, as well as the background as to how we became established. We are certainly open to answering any questions that you may have.

CHAIR - Thank you very much for that. It was quite a fulsome overview of the service from my perspective. I have a couple of quick questions. You commenced on 1 July, not all that long ago.

Ms KEENAN - We actually commenced on 2 January this year and it became an administrative office on 1 July.

CHAIR - Okay, so you have had quite a few months at this. The first question I would like to ask is about the early learnings you have had through the implementation of this. Are there any things we might be able to glean from that process you have gone through over the last few months?

Ms KEENAN - I think the early learnings are [?? 9:42:29] of purpose. We established our vision, we engaged with our stakeholders, the sector, and consumers, we listened, and I think we have responded to their needs. That is evidenced by the number of questions we get coming in and requests for assistance, whether that be informal or more formal assistance. We have worked hard, as Nicole described, to really listen to what the sectors wants.

CHAIR - Do you feel there is a level of acceptance at the coalface? I guess that is an important aspect. How do you feel it is going at the coalface? Do you think it is being received with caution? Let's face it, the health systems in most states have been through certain levels of change over the years and people may get a little bit ho-hum about these things. How are you finding the acceptance at the coalface?

Ms BRADY - 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.

CHAIR - From the clinician perspective, are you managing to get reasonable engagement with the clinicians? How is that travelling?

Ms KEENAN - The clinicians are exactly as Nicole just described in terms of that willingness to engage and the want for leadership. In the recent visit by IHI, we ran specific sessions for clinicians at 7.30 in the morning and had great turn-up. As we redefine the clinical network in terms of people seeking membership on those groups and the programs we are starting to run, there is strong clinician interest in being part of those. The feedback we have when we go

out to visit health services is very positive in the clinicians being out there and wanting to share what they're doing. Doctors in Victoria have access to sabbatical leave and we've even had clinicians requesting to undertake their sabbatical with us.

CHAIR - So the level at which decisions are being made in the clinical perspective is acceptable to them?

Ms KEENAN - What do you mean by that question?

CHAIR - In terms of local decision-making in hospitals, in some cases in Tasmania we are hearing that it is not always immediate enough to suit the needs of the local environment. Have your clinicians experienced that in the past and is this addressing that?

Ms KEENAN - It is fair to say that the clinicians' response to that would be that they feel there would be variability at the local health service level in their engagement with decisions. Remember, we talked about Victoria having the devolved governance arrangement of independent boards and CEOs.

Ms BRADY - Upon reflection, it is fair to say that at the moment and throughout this year, we have been working with the willing. We have a lot of people working in the health sector in Victoria and the ones we have most likely come in contact with have been highly engaged in regard to quality and safety. It will be interesting for us to be looking back at this time next year as we start to embark on some more very specific programs of work to reduce unwarranted variation in practice and outcomes across health to see how we have worked with everybody rather than just working with the people who are highly engaged in this area.

Ms FORREST - We have had concerns raised with us about disengaged management within the health system in the view of clinicians particularly, who are finding it somewhat frustrating by all accounts. I was a midwife previously so I understand what brought about that report and the subsequent decisions to go down this path. I am interested in how this new model differs significantly from the previous one. I assume the previous model Victoria was working under is very similar to the Tasmanian model now. I am not sure how much you know about that, but it seems we have this disconnect between clinical decision-making and management and a lot of frustration going on, and when people raise concerns about adverse outcomes they are often shut down. That is the first part of the question. The second part is, how do you now deal with adverse outcomes when they will inevitably happen - you know that. What is the process around dealing with them? Two parts to the question.

Ms KEENAN - I reinforce what Nicole said, we have been very much engaged with the broad sector. There is a culture of willing. 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 central 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 central event. That is a positive. From my understanding, that had not really occurred prior to our establishment. The other thing that I described that we are doing is looking at our central event

programs. Hopefully, we are going to develop an academy of people who are trained in areas such as human factors and system reviews to help the health services to see when things have gone wrong, what has gone wrong, and for us to then to have that higher-level picture to see whether have we some common themes happening across services. What can we do as the enabling entity to help support services so as to prevent reoccurrences?

Ms BRADY - Just going back to the first part of your question, Targeting Zero called out that there had been some engagement between previous iterations and the senior executive level within health services, but there had not been enough engagement with clinicians and also with consumers and patients and their families. That is why we have elevated those components as well within our priorities and our structures. We would regard our key stakeholders as being each of these three groups. We communicate and meet regularly with health service CEOs and other senior managers, just as we do with the senior clinicians, and we also have our own family-patient advisory council. We use that as a key way of engaging with consumers.

We have employed a consumer who works within the agency to provide advice to us in regard to consumer perspectives and to voice consumer issues throughout each of our work streams. We are trying to make sure that we are working across those different levels to get different perspectives and experiences.

Ms FORREST - What is your annual budget, particularly as compared to the previous department budget for the same sort of area of work?

Ms KEENAN - We will have to take that on notice as to whether we can disclose the budget.

Ms FORREST - There is nothing in the Victorian budget papers in the parliament?

Ms KEENAN - In the last budget that was released in May, there was over five years for the entire response to Targeting Zero across Safer Care Victoria, the department and the Victorian Agency for Health Information. There was $215 million allocated.

Ms FORREST - There would be previous health budgets that we could look at. - I am interested in the cost of this. Much of what is happening makes sense from a clinical perspective. With Tasmania's small population, as we know, we are always complained about by Western Australia for getting too much GST. In terms of the public perception, all this money going to another administrative body, even though there is consumer representation when there are all these people lined up for surgery, for example, and we cannot get people to into acute mental health services when they need it: how do you sell that?

Ms KEENAN - It's in regard to when you have avoidable harm occurring across health care and other jurisdictions are well ahead in developing quality and safety as a key priority. It is an essential part of the health system and the health service for consumers to keep them safe and ensure that they get the best quality of care that they can.

Ms FORREST - Did you look at any other models from anywhere else in the world when you were developing this?

Ms KEENAN - Yes, we've had strong engagement with New South Wales, which has the Clinical Excellence Commission, and also with the Queensland Department of Health, which has the Clinical Excellence Division. Those two jurisdictions have been extremely supportive of

Victoria. As we've caught up with them in regards to developing a stand-alone quality and safety agency, they have shared their work programs and we work regularly with them. Also the ACT is now meeting regularly with us. We meet quarterly as states sharing each other's work, to make sure that where we can we won't duplicate each other's work, but will be sharing and supporting each other in what we're doing.

Mr FINCH - Ann Maree and Nicole, did you confer, or did the Targeting Zero people confer, with those other agencies you just mentioned before drawing up the recommendations?

Ms KEENAN - If you look at the report, they had knowledge and awareness of what's going on in the other jurisdictions. Since we were established in January we have reached out to those other jurisdictions and commenced working with them. As I said previously, they have been very generous and supportive in sharing where they are at in any of their work programs information. IT has been shared willingly with Victoria as we've become established and embarked on our own work program.

Mr FINCH - If I heard you correctly, you said that there were over 170 recommendations in the Targeting Zero report.

Ms KEENAN - That's correct, 179.

Mr FINCH - That's a lot of recommendations. Has the Government decided to implement all of those recommendations?

Ms KEENAN - The Government accepted all of them in-principle. Some could be implemented very swiftly. Others have commenced, and we have a number still under development in terms of how the response will be developed and implemented.

Mr FINCH - It will be that you will move through all those 179 recommendations?

Ms KEENAN - Yes, that is correct.

Mr FINCH - Where have you had the most success? Where have you targeted early in your commencement in January? Where have you had the most success with those recommendations?

Ms KEENAN - We have had a number of successes. We have established an agency from the ground up and we have appointed into our structure. We have had really good engagement from the sector and we have established our priorities. The evidence from the reviews of services and of adverse events is a real shift from where we were, had you asked the same question of Victoria this time last year.

CHAIR - Okay. Unfortunately, we're out of time. We could spend another hour talking about the operation you have happening. It may be that we may wish to clarify something in the future. If you would be happy to receive communication at some point that would be good. Thank you for attending today via phone, it has been very much appreciated.

Ms KEENAN - Thank you.

Ms BRADY - Thank you.

THE WITNESSES WITHDREW.

Ms JANETTE TONKS, NURSING DIRECTOR, WOMEN & CHILD SERVICES, 4K BUILD TEAM, LAUNCESTON GENERAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome and thanks for taking the time to come and be a part of the inquiry. It is a Government Administration A Subcommittee Inquiry into Acute Health Services. It is not a government inquiry as such. It is the Legislative Council committee that is running this inquiry.

All evidence taken at the hearing is protected by parliamentary privilege, but I have to remind you that any comments that you make outside of the hearing may not have that benefit afforded to it. You have been provided with the information for witnesses sheet - you have had a chance to look at that?

Ms TONKS - Yes, thank you.

CHAIR - The evidence you present is being recorded by Hansard and a version of that will be published on the committee website when it becomes available. We will offer you the opportunity to make an opening statement and then members will wish to ask you questions. Before I do that I just want to make sure that you are aware of who you are talking to today. We have the honourable Kerry Finch, member for Rosevears; the honourable Ruth Forrest, member for Murchison; we have Mr Stuart Wright and Ms Allison Waddington, the secretariat, and Roey Johnson from Hansard.

If at any time you feel that there is something you wish to tell us in confidence, alert us to that and we can have a discussion and we will proceed from there. Over to you, Janette, for your opening statement.

Ms TONKS - Thank you. The Women and Children Services at the LGH provides maternity, gynaecology, neonatal and paediatric services to the northern Midlands, north-east of Tasmania, and is a referral hospital for patients from the north-west. There are approximately 1600 births per year, 3000 paediatric separations, and 22 500 attendances in our outpatient clinics per year. We have seen an increase in referrals from the north-west patients at LGH with approximately 15 per cent of neonatal and paediatric admissions coming from the north-west area code. This has been an approximate increase of 4 per cent over the last three years. Approximately 7 per cent of our obstetric admissions come from the north-west coast and that has seen an increase of 5 per cent over the last three years.

The paediatric inpatient ward 4K is a 28-bed ward. Allocated funding for staff is at 17 beds; the average bed occupancy now sits at 17. The ward increases beds as it flexes up as required and when staff are available.

The paediatric inpatient area is due for a redevelopment and rebuild to commence early in 2018 and funding has been allocated for that rebuild. The age groups within the paediatric inpatient area are mixed and include babies and adolescents in varying ratios at any given time.

The LGH does not currently have adequate facilities to provide acute mental health care services to inpatients under 18 years old. At the moment the paediatric ward has one single room that has been modified to provide a safe environment for adolescent mental health patients but does not meet the requirements where there are multiple mental health patients. The current ward

does not comply with Australian Standards. The bedrooms are small and the bathroom facilities do not comply. There are limited family facilities and the ward lacks single rooms.

The new paediatric inpatient development will be a staged approach and designed to allow a level five child and adolescent mental health unit into the future, as per the white paper. The first stage will increase bed numbers from 28 to 29 and the design will allow for an additional seven general paediatric beds to be built but not fitted out. With future funding this will bring the ward up to 36 beds once those seven beds are fitted out.

Currently our statistics tell us the highest number of beds occupied on ward 4K at any given time is 38. Funding has not been identified for the completion of the seven beds.

In the first stage of development, six beds have been designed to meet the accommodation requirements for adolescent mental health patients. Six beds will be fitted out to meet the requirements of mental health patients; however those beds will not be able to be dedicated for mental health patients until funding for the whole 36 beds and staffing has been achieved.

The current occupancy for child and adolescent mental health is approximately three beds per day. This is an increase in 1.5 beds per day over the last three years. Generally at any given time we can have two of these patients who are eating disorder patients.

The layout of the redesigned area is designed to have two separate pods to meet the requirements of the varied age groups of the patients. The adolescent patients will be co-located with the mental health pod and share facilities such as activity room, lounge area and school facilities. There is also a designated outdoor area, a courtyard. The younger medical paediatric patients will be in the other pod with indoor and separate outdoor play areas more conducive to their age group. The general paediatric pod will have two close observation rooms with greater visibility for staff.

Stage one of the redevelopment will provide 29 beds in the ward. Seven single general paediatric beds will not be fitted out until funding is identified. This will increase the possibilities for the general younger paediatric patients being cared for in the older adolescent mental health pod and not in the most age appropriate pod.

Ms FORREST - When you are saying 'younger', what sort of age are you talking about?

Ms TONKS - Generally under about the age of 14 we would try to keep co-located in a younger area with more age-specific facilities for them. Generally if we are going to end up with a 28 bed and we have an increased number of younger paediatric patients obviously we will attempt to provide care in the younger pod but it maybe that they need to be moved into the older area, mixing with the older children. This is the current situation, which we are trying avoid.

There is no funding for staffing resources for the adolescent mental health facility that is being constructed. The white paper indicates LGH to be a level five facility and this requires dedicated qualified and/or experienced registered nurses in charge on every shift and with the majority of staff with mental health qualifications. Also 24-hour access to a registered medical specialist with credentials in psychiatry and certificate in child/adolescent psychiatry and access to an on site or visiting specialist in mental health. At the moment Launceston only has an outpatient child and adolescent mental health service. It doesn't have an inpatient service, and that's what we're trying to achieve.

Funding for the additional registered nursing and support staff, once the development has been completed, to ensure safe staffing in both pods is also being sought, and funding is being sought for our current paediatric nurses to undertake postgraduate study in child and adolescent mental health.

The only other matter I wanted to bring to your attention was the issue we are having at the moment with the lack of accommodation for children in crisis presenting to the LGH for safety reasons with no known medical condition. In the last six months, we have had three adolescents housed with us because there is no other crisis accommodation for them and it has been the safest place. Thank you.

CHAIR - Thanks very much for that.

Ms FORREST - Because this area is another one under development, it is an opportunity to get things right, obviously. It seems from what you have said that the occupancy rate of your current ward, which we visited a few weeks ago, was over capacity. I remain concerned because even though the extra seven beds are being built, they are not being funded, staffed or equipped. Do you have any idea of the cost of that, and what reasons have you been given for not funding these when clearly the demand is there at the moment? It is not a future demand, it is a current demand.

Ms TONKS - Yes, I would have to agree with you. We will be getting separate quotations for the cost of fitting out the seven rooms. An estimated cost I have been given at the moment is about $395 000 if we have that money allocated before we start building, so it is in the initial costings. If the construction happens at a later time it will be $477 000, and depending on how long it would be before we built that there would probably be additional costs attached to that - as well as the disruption to the ward area if it was constructed at a later date.

Ms FORREST - That is the physical environment. As to the cost for staffing the beds, do you have any idea about that?

Ms TONKS - I actually don't have that amount. We're doing that work at the moment with what costing would be required. At the moment we are staffed with registered nurses and medical and support staff for a 17-bed ward. When our numbers escalate, which they do frequently, it's a matter of pulling staff from wherever we can and asking staff to do extra shifts in order to meet those safe staffing requirements.

Obviously with a ward with a larger number of beds, we would be looking at an increased staffing capacity, and with trained paediatric staff in order to meet those requirements. Because we now will be working towards a child and adolescent mental health inpatient area, we are going to require registered nurses with those sorts of qualifications. I have started initial consultations with my paediatric nurses and we are looking at courses available through the University of Melbourne in order for those people to achieve those qualifications. I am seeking funding to provide financial assistance for them to be able to do that because obviously it's in our best interest.

Ms FORREST - These are specialist staff so it's always a bit of a challenge. You can't just drag in an agency nurse necessarily. Currently, how many agency nurses do you rely on to

provide this care? With the rebuild, is that an ongoing challenge, having the specialist nursing staff that you need?

Ms TONKS - Absolutely. There are no agency staff that are paediatric trained, so we don't use any of those. As a department, we have worked on a nursing pool through our LGH pool department, and have given registered and enrolled nurses some significant orientation to working in our paediatric and neonatal areas so they have some skills and feel supported when coming to work extra shifts with us. I would say we would use nurses from that pool at least twice a day.

Ms FORREST - Your overtime rate? I know there is overtime everywhere but is it a particular challenge for you in your unit?

Ms TONKS - Probably not so much. It is a challenge for us but we have the generosity of our nurses who will pick up extra shifts in times of high acuity. Then there are times when the acuity is low. That's why we use the pool method of being able to draw those staff from the pool when the acuity is there.

Ms FORREST - To go back to the issue of the physical location with the redesign, there is a not insignificant saving to be made by doing the work now. What are the barriers to doing it now? You know what you need - the clinicians always do - and administrators don't, necessarily. What is the barrier here to fitting out those rooms? It is not a huge cost in the big scheme to the major project but it delivers a saving by doing it now in terms of the cost of physically doing it but also the disruption and the costs that go on and risks of other complications?

Ms TONKS - When the funding bid was first put in there was a figure calculated that was put forward. We were fortunate to be granted the funding bid, but that was before any design work had been done. Once we started working with architects it became very evident the original footprint we were looking at wasn't something we could achieve. We ended up with a very long ward, which meant we had to double up on some of the services. We then decided to make the two separate pods and a nurses' station in both of those pods and some other utilities as well in both of the pods rather than sharing. I think that probably increased the cost of building a facility like that.

When we were given our original funding bid it was insufficient to build the type of unit we felt we needed. We were fortunate in getting another $110 000 to make the footprint what we wanted because originally it looked like we were having to shrink the footprint which really wasn't going to be satisfactory in our view. We were fortunate to get the footprint but it did mean that in order to keep within the budget we had to make cutbacks, and the seven beds were considered to be futuristic, future planning and future-proofing. It is the way we have designed the ward and we are trying to keep the younger children and the adolescents in more age-appropriate areas.

One of the issues we have at the moment, as you would have seen when you came to visit our ward, is that the age groups can be mixed, which can be upsetting for some of the younger children and families if we have mental health patients who are noisy and disruptive, so that is why we chose to design the area the way we have.

CHAIR - Regarding the demand for mother and baby units, can you talk to us about what you do in a circumstance where you are presented with a mother who is having difficulties, maybe postnatal depression? How do you handle that if you don't have a special unit?

Ms TONKS - That's a huge service gap we have in the north of the state. There is one mother and baby unit in the south. For us to get a patient into that unit involves a significant amount of red tape for us to go through because they only have a number of beds. It is even more difficult for private patients to get into that unit. We will accept those mothers back into the maternity ward if it is appropriate for the age of the child. That causes some issues with infection control, readmitting them from the inpatient area into a maternity ward. We don't have the trained mental health staff necessarily to provide care. Staffing and care management is done through our mental health services at Northside. If the mother is severely unwell it might be more appropriate to nurse her and provide care in North Side, which is the mental health adult facility but they do not accept the baby into that area. That is not ideal, separating mother and baby. The other issue we had is if we do manage to provide care at the facility in Hobart, you are separating the mother and baby from their family unit here, which again is not ideal -

CHAIR - The support network.

Ms TONKS - That is exactly right. There would be circumstances where it might be appropriate to provide a bed on the children's ward - on 4K - for that mother and baby, particularly if the mother is continuing to breastfeed. We do provide an area for breastfeeding mothers, even if they are coming in for a surgical procedure. To keep mothers and babies together we do provide that service for them.

CHAIR - In your experience, what would be the level of demand for the mother and baby unit? How often do you find yourself in a situation where they present?

Ms TONKS - We have probably had two or three cases per year. I would say that if there was a facility, then it would a lot higher demand. People in the community know that there is not a facility so they try to manage it through other means. A lot of times these cases do not get managed at all. We see these women re-present back with pregnancy and their mental health issues have not been resolved from their previous pregnancy. It is a huge service gap in our community.

CHAIR - There are no private service options?

Ms TONKS - No. We did have consultation with Calvary Health Care when it was setting up its mental health unit at St Luke's, but it was not in a position to open it up to a mother-baby unit.

Ms FORREST - A terrible failing of our system in Tasmania.

CHAIR - It is really. You mentioned three adolescents staying in, caring for them because they had no other care options.

Ms TONKS - Exactly.

CHAIR - How often do we see this in Launceston?

Ms TONKS - Three in the last few months is extreme, I would have thought. There would have been one every one or two years where we had to provide crisis accommodation.

One of the children had been a mental health patient in our facility for quite an extended period. She was then cared for and managed. Then there was no accommodation for her to be discharged into so she stayed with us for an additional three or four weeks while child safety and social work services and many other services tried to find accommodation for her somewhere in Tasmania or even in Victoria.

The other two patients who presented to the ward were patients who arrived with no medical condition whatsoever. They simply had become estranged from their family and this was the safest place for them to go. Lacking other crisis accommodation, it is the best place for these children, but they are taking up an acute medical bed. This concerns us. If we have one of these high acuity days and beds are required then it puts us in a very compromising situation because there are no other paediatric in-patient beds in the north of the state around the Launceston area.

CHAIR - Presumably the nature of the person's issues and problems is far removed from the service that you are providing.

Ms TONKS - Exactly right.

Mr FINCH - Janette, do you get a sense of an increase in mental health issues in young people these days?

Ms TONKS - Yes, I do. We have seen an increase from about 1.5 days to about three days on average in the last five years, so that has been an increase. We have had up to eight or nine mental health patients at any given time.

Mr FINCH - Can you put that down to anything in particular?

Ms TONKS - We always have at least about two eating disorder patients. There is a lot of stress on our young people these days to perform. They get pressure from their peers. Also a lot of it results from the fact that the parents may have mental health concerns. They are not in a position to be able to provide support, care or even acknowledge that their children also have issues. It's become a bit of a cyclic event.

Mr FINCH - You are talking about the future of your area, do you think you have future proofed the area to cater for young people with mental health issues?

Ms TONKS - I think initially we have. We will be setting up six beds dedicated to mental health patients; they have specific requirements. They can be used for normal medical patients, should it be required, if our numbers of mental health patients are low. At the moment, that probably meets our requirements. Our eating disorder patients can also be nursed in our other single adolescent beds. We have two-bed rooms as well, which we thought was quite conducive to their requirements.

The way that the ward has been designed allows for future proofing to extend further out from the adolescent mental health pod. It provides an area underneath it. Also we could build above that area. There is still scope to future proof; to rebuild a larger area should that be required.

I would like to see more outpatient models introduced for the mental health area. We do tend to keep them in hospital a little longer than some of our mainland colleagues. That is because we

don't have the outpatient resources to be able to implement things like the Maudsley model, which they use at the Royal Children's Hospital. It is more of an outpatient model. If we focused on our outpatient resourcing, we could probably prevent having children in hospital for as long as we do.

Mr FINCH - In some of the figures you mentioned earlier, Janette, you were talking about the numbers and the percentages coming from the north-west. Is that showing an increase and will that keep increasing?

Ms TONKS - It has shown an increase. I'm hoping it will plateau. Their paediatric inpatient increase was seen around the time that Mersey ceased providing inpatient service for their patients. Similarly, we saw an increase in numbers for maternity services when the Northern Integrated Maternity Services was implemented and the Mersey stopped providing births. I believe that it will plateau, but we're still waiting to see that. It is still tending to trend up at about 2 per cent.

Ms FORREST - Do you believe that the increase in obstetric admissions happened when the Mersey stopped birthing? Are you providing more antenatal care as well as labour, birth care and post-natal care from the LGH for the north-west based women?

Ms TONKS - We're trying to avoid the antenatal care. The Mersey still has a very good, robust midwifery antenatal service. We are encouraging the women who are choosing to come to Launceston to have antenatal care in their local area. We have a referral process in place so that they present to our antenatal clinic at around about 36 weeks for a medical review prior to their coming and delivering at the LGH. Where possible, if they are low risk, they are suitable for midwifery care and we try to accommodate their antenatal care at the Mersey.

The inpatient area has probably increased the most in maternity, for a number of reasons. Women who are living east of Devonport may choose to come to Launceston rather than go to Burnie. There have been a number of occasions where women have been transferred from the north-west coast for a variety of reasons: the nursery may not be at capacity to take a younger gestation baby; or the locum obstetrician may not be in a position to want to continue with the care of a high-risk patient, so they will come through to us.

Ms FORREST - We have seen the extraordinary use of locums in the north-west and we also have some of the poorest health outcomes in the state and that includes our pregnant women, unfortunately. There are a lot of morbidly obese pregnant women and increasing numbers of gestational diabetes. Are you seeing more of those right throughout their pregnancies as a result of that?

Ms TONKS - Yes.

Ms FORREST - What is the percentage would you put down to that? The number of women who have to travel for this care because of their pre-existing conditions?

Ms TONKS - I would not be able to comment on numbers, but I worked in the antenatal clinic as a midwife for 16 years prior to this role. Just anecdotally, looking at the numbers, the number of high risk patients coming from the north-west was gradually increasing. I am sorry I could not really give you a number.

Ms FORREST - But it has continued?

Ms TONKS - Yes, it has continued to increase. We felt that once the north-west coast had a stable obstetric workforce that that number would start to plateau because as a level four maternity hospital they should be able to provide care for babies of 34 weeks. What we are finding is still with some of the locums that they are using down there they are choosing not to take on the high risk patients and refer them through to Launceston for care.

Ms FORREST - If you had a magic wand what would you do with your development that could make it better for you?

Ms TONKS - I would like to see all seven beds fitted out at the first stage. I would like to see funding for appropriately trained staff to staff the inpatient area, particularly with the mental health patients, which is concerning to us. I would like to see further developments for our outpatient areas both with our paediatric and our pregnancy gynaecology outpatient areas. The way that we have designed this paediatric inpatient area, the level underneath is quite conducive to providing an outpatient area and then we can start to look at some of our models of care and provide some better services for our patients in the north.

Ms FORREST - In terms of the young people that you have had to house due to the lack of crisis accommodation, what discussions have you had around dealing with that? Obviously, that is the last resort you would hope, using a hospital bed. It is very expensive for a start and it is not really the right environment and all those sort of things, and it bring with it a whole heap of other risks for the current inpatients as well as for the young person themselves. What discussions were had, that would be with the minister, Mrs Petrusma, I imagine wouldn't it, in her area? Where do you go with that?

Ms TONKS - It has been raised with our group director that it is not an ideal situation. There have been discussions. Each time we get another child in the situation there are lengthy discussions with child safety services and social workers. They are doing all they can to provide the right environment but the different facilities that take children in these situations either agree to or disagree to take them for a variety of reasons.

Ms FORREST - Is it a capacity issue? Or not the capacity there, or they do not have the skilled staff?

Ms TONKS - I think it is a capacity issue.

Ms FORREST - We talk about bed block in a range of areas. This is effectively another form of bed block. I am sure the young people would not want to be seen that way but that is what it is. There must be better places for these people to be housed.

Ms TONKS - That is right.

Mr FINCH - Janette, talking about your wish list there, it sounded fantastic. However, just to hone in on that staffing and getting the right people and the right training particularly for the nurses who are able to have that mental health accreditation or skills that they need, I want to explore that a little bit. If you do have an expansion, if you get the opportunity, how difficult is it to get the nursing staff that would be applicable to the desire that you have for them to be skilled in a certain way? Is it difficulty or easy?

Ms TONKS - That would be relatively easy. My staffing model, I will be looking at probably 10 to 15 paediatric nurses who have skills in mental health.

Mr FINCH - How many would you have now?

Ms TONKS - I met with my paediatric staff on Friday and I have 12 people at the moment that have put their hand up and said, 'Yes, Janette, I'm interested in doing some post-graduate education in child and adolescent mental health'. We've identified a suitable on-line course through the University of Melbourne. The cost is $12 000 to get a graduate certificate in child and adolescent mental health.

Mr FINCH - Per nurse?

Ms TONKS - Per nurse. That is obviously quite expensive for each individual to look toward that cost. They can go on to a graduate diploma and a masters if they choose to.

Mr FINCH - Would the hospital provide that? Would the THS provide that money or would there be an arrangement with the nurses? Would they be required to pay that themselves?

Ms TONKS - At the moment they would be required to pay that themselves. I would be very hopeful that I would be successful in putting in for some additional funding for them. There are a number of scholarships that are available to registered nurses, which have already closed for the beginning of next year. I would like to see at least three or four nurses start off next year in readiness for us opening up this area and then probably another three or four over the next two or three years, so that we can gradually get our skill levels up to where we need them to be.

I'll be putting in an application with specific costs and keeping my fingers crossed that someone will be able to provide that funding. There isn't any funding within our women's and children department for that. We feel quite passionate about the fact that we need to provide some financial assistance to these nurses, because obviously it is a requirement. It is better to have paediatric mental health nurses rather than just mental health nurses who don't have any paediatric experience, because the numbers fluctuate significantly. We need the nurses to be versatile and be able to work across all the scope that we would be providing in the ward.

Mr FINCH - Is there something lacking in the system in Tasmania where we're not able to provide that training here locally?

Ms TONKS - UTAS is the university that we would normally work through and they don't provide a course of this nature. The course that we have identified in Melbourne meets the requirements of the Royal Children's Hospital. They've looked at what the industry requirements are for their facility. We model a lot of our patient care on the Royal Children's Hospital, so we felt that that course was able to meet the learning needs of our nurses.

CHAIR - You've been asked about the magic wand. What would be your biggest frustration? What would be that thing that you would really like to see addressed that is of a major concern to you in terms of the way the whole system operates within the LGH?

Ms TONKS - How the system operates?

CHAIR - Within your area.

Ms TONKS - My biggest concern, obviously, is not being able to open up the seven beds. I think the process that we've gone through to get to this stage where we're nearly ready to go out to tender to build this fantastic facility was the fact that there should have been a lot of ground work done before any sort of funding bid was put forward, before any funding was allocated to this. We didn't know when we said we want X number of dollars to build a new paediatric ward that it was going to be inclusive of a child and adolescent mental health ward. We didn't know that it had to be a long skinny ward, and that we would have to double up some of the services.

If I was to do this again I would be investing some time and energy into working out exactly what it was we needed and what was achievable before we said, 'We want this and please work out how much it is going to cost us'. I think that was missing in this, which is why we've gone over budget on what the initial funding was.

CHAIR - With a project like this at various points there are checks and balances. Was there not an opportunity moving this all forward for you to revisit with the project team as to how this was going to operate?

Ms TONKS - We had regular meetings with the project team all the way through the process but it always came back to that bottom figure that we were given this much money -

Ms FORREST - The budget was set before anything else happened - is that what you're saying? It seems an odd way to do it.

Ms TONKS - Yes. There is a fair amount of the budget that goes out into architect fees and other incidentals that, to a clinician, is something you learn along the way.

Ms FORREST - But you are a heath professional, not a project manager as such.

Ms TONKS - That's right. It is these sorts of things, like when you thought you'd received $7.8 million it was actually $6.9 million, and then you start working with architects and say, 'We thought we'd build a facility like this', and they say, 'No, you can't'.

Ms FORREST - That is interesting because you have this long, skinny building and I can absolutely understand that being a nuisance. If it was a big square you could put your central monitoring in the middle. Why are you stuck in a long, skinny place?

Ms TONKS - Originally it was clinicians thinking together about this 30-year-old inpatient facility that needed an upgrade and where we would extend to. Originally we thought we would extend the ward heading west towards the maternity ward and meet up with them - unfortunately, that wasn't something we could do from an engineering perspective - and allowing light into different parts of the maternity ward and nursery. Then it was suggested to continue farther out towards the southern end, over the car park. Originally we hadn't even considered that concept because we thought that bit of real estate at the LGH was not up for grabs. We also thought we might have been able to extend a little bit to the east, along the Charles Street side, by a couple of metres, because specialist clinics had built underneath and increased their footprint, but unfortunately, with their budget costs -

Ms FORREST - They hadn't done the foundation strongly enough.

Ms TONKS - We lost that opportunity there as well. It was a little bit short-sighted, in my opinion.

CHAIR - When is this to start?

Ms TONKS - Probably February or March. With our planning we have made sure we have the foundations to support a level underneath and two levels of car parking underneath as well.

Ms FORREST - Which would cost more to do, but it is a long-term saving if that had to come out of your original budget.

Ms TONKS - Some of it has come out of our original budget but some of it has come out another budget. It has been very difficult, if you're talking about frustration, to find out exactly what each component is costing us. There has to be movement of the big gas cylinder from the car park area to the front of the hospital and we're trying to find out how much that is costing us.

Ms FORREST - Do you have to pay for that in your budget?

Ms TONKS - No, that is now coming out of the capital works budget but originally it was going to come out of the budget, so it was really about keeping tabs on who was paying for what and how much it was costing.

Ms FORREST - We talk about being 'lean', but you have a long, skinny ward and that isn't lean. How can you run a lean operation in a long, skinny ward? You have put it into two pods which will probably help that a bit. Do we need this level of thinking to go back - it is probably a bit late now for this - but if you look at the Royal Hobart Hospital redevelopment with the acute mental health inpatient facility there, there is a whole range of contentious issues around that. We are hearing this here, when it seems to me that there needs to be a different level of thinking before we actually start. Is that what is happening here?

Ms TONKS - I don't know that we would have come up with anything too different to what we have ended up with had we gone through that thought process before we started. It did become very evident to us quite early in the project that we were going to end up with this long, skinny ward, and what sort of model were we going to use with this? That is why we have pretty much set it up into separate pods, where we will always need to have a minimum of two registered nurses in the adolescent mental health area. We are looking at communication systems so the staff can communicate with each other, because if someone is looking for a particular person they don't want to be walking up and down.

Ms FORREST - That's what I'm talking about - the number of miles you do in the day as a nurse -

CHAIR - Very fit nurses.

Ms TONKS - Yes.

Ms FORREST - But it's impractical and inefficient.

CHAIR - Absolutely.

Ms FORREST - It's a waste of money and time.

CHAIR - From an observational perspective as well.

Ms FORREST - Yes.

Ms TONKS - There are three different communication systems we are currently looking at to see which one might best suit our needs, but I think what we will end up having is that when each nurse arrives on duty for each day they will take a device like a mobile phone which they will carry on them which will have particular numbers, so if anyone is looking for them they will know to ring that number. There is also a device where if the nurse is looking after patients in beds 1, 2 and 3 today, the patients will then be able to call straight to that nurse's mobile device rather than ringing the over-bed bells. There is a couple of systems -

Ms FORREST - Some benefits to that.

Ms TONKS - Yes. It all comes at a cost, but that is exactly the sort of investment we need to make in order to make the flow of the ward a lot better.

Ms FORREST - If the powers that be say that monitoring system or communication is going to cost X amount of dollars, how much does it cost for them to run up and down the corridor for half an hour looking for someone? Put a price on that.

Ms TONKS - Yes, and the wear and tear on the nurses. They get exhausted by the end of the shift.

Mr FINCH - You mentioned parking earlier. I suppose it is always where exacerbations occur, particularly around hospitals, and the LGH cannot avoid that situation. What would your parking be when you talk about it being underneath? Would there be an allocation for staff or for patients? How many parking spots would there be?

Ms TONKS - During construction we will lose about 15 car spaces.

Mr FINCH - These are designated to -

Ms TONKS - To the public.

Mr FINCH - Just general spaces?

Ms TONKS - General public spaces, yes, not necessarily staff spaces. That is why the construction firms come in. They have an area where they need to set up their construction site. I believe that the car parking spots on the western side that were used for a lot of the construction with the allied health area will soon become available. There are 15 or 20 of those so hopefully that will offset the number of car spaces during construction.

During the construction phase there has been some work done on that existing car park at the moment that don't meet car parking requirements with the spaces and the way they are configured. I understand all that will be rectified and brought up to standard and they might lose a minimal number of car spaces during that process. I can't be sure, but it might only be five or six spaces that they will lose. If we get the opportunity to build stage 2 and there are two levels of car

parking, there will be an underground car park and then another on top. I believe that will increase the car parking by around 80 or 100 spaces. I couldn't exactly tell you how many, but around that vicinity.

Mr FINCH - It is not entirely connected to acute health but I just thought that if there was an allocation for your part of the operation that might make a difference to the way your operation can be smoothed out for the staff and their parking requirements.

Ms TONKS - Yes. It's a fantastic opportunity for parking for the general public who are coming to our patient clinics. They seem to be the ones who struggle the most and are late for their appointments because they can't get a park, particularly our pregnant women. I would love to see some designated parking for people attending outpatients. Things like that or just general public car parking would be ideal.

Ms FORREST - On adolescent mental health, I assume the unit will be for the whole of the north of the state. There is no plan at this stage to provide this sort of service in the north-west at all?

Ms TONKS - Correct.

Ms FORREST - You talked about the lack of a mother and baby unit. I have seen women in Burnie transferred to the Spencer Clinic there and it's really inadequate. So there is obviously unmet demand out there. There are a lot of young people in the north-west with mental health challenges, not just eating disorders. What is your average length of stay? You did mention you're not using the Maudsley model and you tend to keep them a bit longer. Also, do you think you're going to see a big rush on demand and you're not going to have adequate facilities?

Ms TONKS - I think if the beds are there they will be filled. We had that exact discussion when we were doing the planning and tried to get some information about how many patients we thought might come from the north-west coast and we were working with our child and adolescent mental health team on the outpatient service when we were looking at that. It was a case of if we had 20 beds, we were sure 20 beds would probably be filled, and if we had six beds then six beds would probably be filled, so it was a bit of a juggling act. I guess in essence we felt that six beds was going to be sufficient and -

Ms FORREST - Is that with a longer view of getting more community-based adolescent mental health services?

Ms TONKS - Yes. The six beds have no hanging points and have extra safety glass and things like that so the children can't harm themselves. We generally find with our eating disorder patients that they don't necessarily need an environment like that and can be cared for in a normal sort of patient area bed. We had quite a few discussions but had no real data to work with to advise us on that, so we are hopeful that six beds will be sufficient.

Ms FORREST - That was the higher acuity beds?

Ms TONKS - Yes. We have the two observation rooms as well, which obviously -

Ms FORREST - In the new design?

Ms TONKS - Yes, which are for those patients arriving who need close medical observation, particularly for children who have overdosed. Obviously they need that close medical observation in order to be stabilised before we move them into the mental health area to recover.

Ms FORREST - What is the average length of stay for your eating disorder patients?

Ms TONKS - We're probably looking at about 26 to 30 days.

Ms FORREST - That's a long time.

CHAIR - I can't recall whether there was an outdoor component of your development. Just knowing that there is - obviously adolescents need space -

Ms FORREST - And small children.

CHAIR - And small children. I just wanted to touch base on that.

Ms FORREST - And the education side - your school room and everything - that is all maintained?

Ms TONKS - Yes.

CHAIR - We saw that in action. Okay, thanks very much for coming in and presenting to us. We really appreciate that.

Ms FORREST - Unfortunately we don't have a magic wand, though.

CHAIR - No, we don't have a magic wand so we can but raise these issues. Thank you again for taking the time. We know you are a very busy person.

Ms TONKS - Thank you very much. It is a very busy time of year for all of us.

THE WITNESS WITHDREW.

Dr STUART DAY, AMA TASMANIAN PRESIDENT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Just to make sure we are all on the same page, this is the Government Administration A Subcommittee inquiry of the Legislative Council. It is not a government inquiry as such. It is a Legislative Council inquiry into acute health services in Tasmania.

Dr DAY - Yes.

CHAIR - All evidence taken at the hearing is protected by parliamentary privilege, which I am sure you would be aware of by now, seeing as you have met with us a couple of times. If you have anything to say outside of this hearing, that may not be afforded the same privilege.

Dr DAY - Sure.

CHAIR - A copy of the information for witnesses has been made available to you. Are you aware of that and its contents?

Dr DAY- Yes, I have seen that, thank you.

CHAIR - The evidence you present today is being recorded on Hansard. It will be made available on the committee website at a later point. If during the hearing you feel that there is something you wish to say to us in confidence, please let us know and we can consider that as a committee and we can go forward from there.

Dr DAY - Sure.

CHAIR - I would like to introduce my colleagues for the record: Kerry Finch, the member for Rosevears; Ruth Forrest, the member for Murchison; and we have Mr Stuart Wright and Ms Allison Waddington, the secretariat for the inquiry. We will give you an opportunity to make some opening comments or remarks, if you would care to do that, then we will follow up with some questions from your submission.

Dr DAY - I would like to make some opening comments about the THS in general, and particularly the governance. THS, as we are aware, came into existence in July 2015 with the aim of bringing the four acute hospitals working together to deliver safe and high quality care that avoids the costly duplication or inefficient services.

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

The AMA believes that Tasmanians deserve access to a well-performing public health system that supports our hospitals in delivering high quality health services with a minimal level of bureaucracy. The AMA believes that the THS as a central bureaucracy that has been developed over the past two and a half years by its CEO and its governing council is of a seriously flawed design. It is top heavy and urgently needs to be cut back to size with staff and resources

re-focused back to the state's major hospitals. The AMA is for good governance in health, a positive management culture and removal of unnecessary bureaucracy. We believe that current bureaucracy is diverting resources from our hospitals and thus patient care.

The AMA lacks confidence in the THS CEO and the oversight provided by the THS governing council. Our view is that the top heavy bureaucracy is prone to micromanagement, which has resulted in botched health policy delivery. We have seen disastrous Royal Hobart Hospital bed planning during the re-development. We have seen dangerous emergency department over-crowding. We have had failures in mental health bed and service planning. We have had impairment and loss of specialist training program accreditation at multiple hospitals. We have had quality and safety system confusion. We have credential in-system failures and also a very confused system.

The AMA is particularly concerned by the adverse impact that this dysfunctional THS executive is having on the administration and function of the public hospitals, including the delivery of patient services and maintenance of accredited college training programs. Of concern is that the THS governing council appears unwilling to address the dysfunctional nature of the relationship of its senior THS executive group, and continues to allow the extreme risk that this poses to the administration of the health system to go unaddressed. This is a high level governance failure in our view. Unfortunately, our view is that the THS governing council is out of touch with the operational hospital reality. It appears to have an extremely distorted and overly optimistic impression of what is happening in Tasmania's hospitals.

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

We have increasingly received reports of dysfunction in the senior THS central bureaucracy and fear that this is having a debilitating effect on the ability of our hospitals to get on with the job of delivering services to patients.

While I have painted a bleak picture, there are some suggested solutions. There remain good committed staff within the health system. One, we need to acknowledge the current failings in the structure, the process and the culture of the THS and recognise that there is no quick media fix to this and general reform and engagement is urgently required. This will need to be driven from the highest levels. We believe we should consider that the DHHS secretary take on THS CEO's statutory roles. This would allow reform and restructure of the governing council and they could be held accountable for managing the THS executive and consequential service outcomes. We could also reform the THS executive structure making it smaller in size with its focus on high-level strategic planning, monitoring of performance, policy and organisational compliance of what are the hospital regional level operational structures.

We need to continue, in our view, to build hospital and regional level capacity, accountability with devolved operational authority to plan and deliver services within the over-arching framework set by the THS and the DHS. We need to ensure that THS staffing decisions and the decision-making about the staffing is devolved and managed where it is most effective: at the

hospital and regional level. We need to build a positive culture in the THS executive by leveraging off the strong, positive hospital regional cultures that do exist rather than creating conflict through the recent failed attempts to eradicate them.

I thank you for the opportunity to provide evidence today.

CHAIR - Thank you very much, Stuart. There are certainly some strong opinions coming forward. It is interesting to look at some of those aspects that you are dealing with on a daily basis. I am interested - when you talk about a toxic and dysfunctional executive, that it is top heavy, needs to be cut back to size, refocused back into each hospital. Obviously this attempt to set up a single Tasmanian health service was to try to overcome some of the duplications in the system and to save money. Do you see that if we go back the other way - if we centralise it back into the individual hospitals - that there is an opportunity there maybe, and I am playing devil's advocate here, for the same situation to occur? Could we have hospitals that are not really connected and communicating with each other as far as the services that they are trying to deliver, the staff that they are employing, that you might actually get back into the same old situation?

Dr DAY - We do not want to go back to the old competitive system. The ideology of the old system was you have three major competitors and the competition creates efficiency. That system clearly did not work. We are quite supportive of things like the role delineation framework which says, what can Tasmania do in different regions and what are the interconnected supports in order to do that? If it is safe and the interconnected supports are there let us do it locally because that is where patients are.

Our vision is that the THS will bring it all together, can drive that vision and that has full support. But what we have seen is the THS that says we do not need any operational people in hospitals because central office will run the show. Central office is a long way away even from the hospital they are close to in Launceston. Today there was an issue that we needed to deal with and we needed to make an operational decision about. Yet there was nobody empowered to do that. You tell us the bounds of our operational requirements, the resource allocation, and the strategic direction then devolve it to that hospital to get on and do that job and deliver for you.

CHAIR - Some of the information coming to us shows the degree of frustration with clinical decision-making, if I can say that, with there being no single point they can go to to get a decision to be able to undertake their day-to-day duties. Do you agree with that viewpoint, that that is what has happened? That it has devolved to the point where it is functionally inefficient and basically bad for the patient?

Dr DAY - Essentially yes; we very much agree with that. We're not pushing to say one person in a hospital in Hobart or Burnie should be able to make serious strategic decisions that have implications across whole hospitals or whole regions, or even the whole state. But there should be enough heads within each hospital that bounce those ideas around rapidly when you have a full emergency department and can put in place the process that solves today's problem and then how we are going to deal with tomorrow. Tasmania needs to realise the issues Burnie and the north-west are dealing with will be different to the issues the Royal Hobart Hospital deals with. When there are common issues, let us leverage off each other, but each region has some unique issues that need to be responsive in those regions.

CHAIR - Having spent 20 years in the health service myself - in the ICT arena, not at the coalface of surgery and the like - there was a fair bit of parochialism that existed as a result of

each hospital doing their own thing. How do you see that being addressed in the model you are putting forward, talking about the back-office functions and the software environments that might exist to support the services clinicians need and those sorts of things? How do you see bringing it back into individual hospitals meaning that they might go back to a parochial circumstance?

Dr DAY - One might say 'parochial' and another might say a culture that supports and gives to their local hospital and wants to see it doing the best it can. There has been a significant shift in thinking. People are not thinking now of just the hospital. Yes, they are thinking about their hospitals on a day-to-day basis but we are also asking how that fits with Tasmanian health care as a whole. That white paper concept of having to think bigger than locally with every decision, not the minutiae of operational decisions but those that are the next step up, is happening, but there is no mechanism now by which those decisions are populated and coordinated and blossomed. Did I answer the question?

CHAIR - I think you did.

Ms FORREST - On the amount that this declined, it saddens me enormously because I was a strong supporter of the one THS and would like to have seen that initially and we might have been able to get a better arrangement, but anyway, here we are. You start to question yourself about whether it was the right decision to push for one. However when I talk to clinicians all around the state, it seems to me it is the structure that is the problem and not the model itself. I think you were saying one body, like an executive, that is responsible for strategic direction and policy development, human resources, IT, payroll and those things that are not clinical decisions, can be managed by a state-run body. The problem seems to be with the local management and the clinician input and decisions.

When you were talking, I wrote down 'allowing local clinicians to determine local solutions', and you said that each of the three main hospitals, counting Mersey and Burnie as one, had their own unique challenges. Is that how you see it, having the overarching body that does all the generic and common things to all facilities and then locally made decisions reflecting the local needs of that community and that hospital? How do you set it up, if that is right? What do you need to do and what do we need to change to make that happen?

Dr DAY - In the last two and half years what was said was we don't need CEOs at our hospitals - delete - we will call them several different names, and nobody was clear what decision they made in the system and we are still not clear as to what role they play. Everything has to go through the central office, down to minutiae, such as whether we replace the anaesthetist who just left. That has to go centrally. It is quite obvious that if you want to continue to run the seven theatres you've got then if you've lost one anaesthetist you replace them. Why that needs to go for an essential approval process is just unclear to us.

Ms FORREST - Just to fill the position, not necessarily who you fill it with?

Dr DAY - Yes - we're not creating a new position, we're just filling a vacancy. A lot of that stuff was done fairly effectively with the devolved structure when we were all 'competing', but what we weren't effective at was saying, 'Well, Hobart has five endocrinologists and they want to employ two more,' and they're going to offer a better service and everybody can come to them. Strategically you would say we've got to deliver endocrinology services across the state. If you want to employ two more people that's fine, but you have to supply a service to the state, because otherwise you're not allowed to employ them. The clinicians are saying, 'Yes, fair cop' to those

sorts of decisions. We want those decisions coordinated such that services aren't largely different when they don't need to be.

That doesn't overcome the challenges of recruiting people to work in Launceston and Burnie versus Hobart. That's just the world we live in, but at least it says there is some responsibility for more than just your own backyard. Does that make sense?

Ms FORREST - I'm really interested in what it is that needs to change? I believe the intent was right - I think that's what you're saying.

Dr DAY - We agree.

Ms FORREST - Somewhere between what it was and where it is, some good things of the former system, the competing system, are happening and good things are happening within the current model, but there's a bit of a gap in the middle, so how do we bring it together? What needs to happen to get the best of both worlds?

Dr DAY - The white paper vision was a good vision, and you put an executive in to drive that vision. However, our statements are clear that the person they put in to drive that vision was just wrong and had an operationalisation of that vision that has been quite destructive.

Ms FORREST - Can you describe the structure as you see it? If you had to draw a mental picture of the structure, how does look in your mind?

Dr DAY - In our mind, what we currently have is a central office that has all control within a core group of people. Over this white paper period and the two-and-a-half years since, there has largely been a dismantling of any hospital structures. In the last six to eight months we've had the slow, and we're still reconstituting, local hospital structures. There has been some devolved responsibility in Hobart. Hobart had no executive, no real CEO, and they've just knocked down half their hospital.

Ms FORREST - There are bound to be challenges.

Dr DAY - Very challenging. We've just now appointed a clinical management executive of that hospital in the last couple of months, so we're two-and-a-half years too late, whereas two-and-a-half years ago we did have that executive. The vision we see is to have a local hospital governance structure run by, call it what you will, a CEO of that hospital, that fits within the framework of the state and has responsibilities for the strategic direction developed for the state and the white paper.

Ms FORREST - You talked about a very top-heavy structure. If you had your board doing the high-level policy and strategy, then as far as the governing council goes, or whatever you want to call it, would that be a collective of those people in charge of running the hospitals? Is that the sort of structure? I'm trying to understand what you see as the vision of the structure?

Dr DAY - The board is an odd concept; we don't really get its role. It has a statutory role, but you do need a core group of people. We added the THS executive on top of the DHS executive, and if you are adding five to seven people, you have had to delete people out of the lower sections of the system in order to pay for it. Therefore you have let people that are not up to the job, trickle along the hospitals, and that is actually where all the business is transacted. The size of the

THS executive probably needs to be shrunk to much fewer people, and put that money back into decent people running on-the-ground operational processes in the hospital.

Ms FORREST - Clinical leaders, you are talking about?

Dr DAY - No. We need executive leaders, administrators, good quality administrators doing the day-to-day running. My view - and the view of the medical profession - is that clinicians are best being clinicians and having some sort of management function. As soon as you detach yourself to just management, you lose track of what is actually going on on the ground.

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

Ms FORREST - It is interesting you are suggesting that the secretary of DHHS could be the head of the THS. The DHHS has a slightly different role now, doesn't it?

Dr DAY - Yes, it does.

CHAIR - I think it is purchased to provide a model. That is what it is built on.

Dr DAY - That is right.

CHAIR - Whether that is still relevant today -

Dr DAY - What we are looking at is, we need rapid change, in our view. We have a CEO that we have no confidence in, and they are hard to come by. It took us well over a year to get the current CEO. We need change, and we need it rapidly.

There are people that could blossom within a smaller executive. So you need a statutory role of the THS so you can deliver that statutory solution by using that mechanism and it can be done rapidly.

CHAIR - With respect to that model you are talking about, I presume you are also suggesting a quality focus and patient focus rather than just the dollars. That seems to be some of the messages that are coming to us. Do you agree with that, that it may be too dollar focused and not patient outcomes focused?

Dr DAY- Healthcare, to a certain extent, is always going to be dollar focused in the sense that there is never enough, if you like. We have to balance what we as a community are prepared to fund for healthcare. But within the envelope that our community gives us, we need to spend it wisely and deliver the highest quality care we can deliver with that money.

To answer your question, if you are paying money that is just delivering confusion and keeping us concentrating on constant change or process for process sake, that is wasted time which is wasted clinician time, which could be then re-focused back on your patients.

CHAIR - We had the opportunity to talk with Safer Care Victoria this morning. Are you aware of what they are doing in Safer Care Victoria?

Dr DAY - No.

To pick up on the statutory thing, prior to the THS formation, we had to purchase a provider mechanism all within the DHHS.

CHAIR - Still operating?

Dr DAY - Yes, we were theoretically doing activity based and purchase provider, and there was just one DHHS. It can be done.

CHAIR - Yes. That is fair enough.

Ms FORREST - Can I just go to the Deloitte report. When was that initiated?

Dr DAY - I cannot tell you the exact date, but Deloitte came and visited most of the senior clinicians within our hospital system and chatted to them all.

Ms FORREST - Roughly when was that?

Dr DAY - Within the last month or so. I cannot get you the exact date I am sorry. They said that the Government commissioned them to come and chat to them about governance and executive function and how we thought the THS was running.

Ms FORREST - The committee has requested that report from the minister. He said there is no report. I think that has been said publicly as well.

CHAIR - Basically a work in progress.

Ms FORREST - No doubt we will question him about that. The heads-up on it, is, as you said yourself, Stuart, a lot of information suggests that there is a lot of dysfunction and some serious deficiencies in the system. You would think that that would be reported back even ahead of a final report. Would you expect that to be the case? Or do we think they would wait for the final report? Did they give any indication?

Dr DAY - The same as you, we have told these things. There is indication and feedback through that process of gaining information that it is what they were hearing. I am not sure whether it is all written down in a final report. I have no further insight than you on that. One would expect that if you pay Deloitte, which does these things regularly and as an external organisation is good at them, to give you an opinion then they would give you an opinion.

Ms FORREST - Fairly promptly?

Dr DAY - Yes.

Ms FORREST - In terms of adverse patient outcomes, which is a term of reference, what is the process from your experience? What is the reality of how central events are dealt with and how adverse outcomes are investigated and reported?

Dr DAY - Currently, we are not sure, to be honest, how that is dealt with. The person who was heading patient safety has left the organisation. During her time we took numerous backward steps about patient safety. Patient safety is core to our business. Clinicians as a whole want to do better all the time. To drive patient safety, you must have an open organisation that wants to seek that information and does not use it as a punitive mechanism,

Ms FORREST - Do you believe that is happening? There is a punitive approach to this?

Dr DAY - Very much so.

Ms FORREST - Do you want to elaborate on that? That is what I am hearing?

Dr DAY - Because they were separate, each of the hospitals had their own internal processes. I am not saying they were perfect. They existed. That was reorganised,

Ms FORREST - Like a mortality-morbidity committee? That sort of thing?

Dr DAY - Yes, they still exist. On the higher level, if we are seeing episodes within the one hospital, then the other hospital should leverage the learning of that. That should be rolled across a relatively small state. That process should be bringing together all those groups wanting to do better. Most people are off on sick or stress leave to be honest.

Ms FORREST - The ones who do the reporting on those matters?

Dr DAY - Who do the work on the ground because of the toxic culture that was developed under that previous incumbent - very punitive, very fearful. When you get that culture people do not report. I know something is wrong. That is where our reference to the Mid Staffordshire inquiry goes. We felt we were in that sort of regime. That is not conducive to good patient safety.

Ms FORREST - Safer Care Victoria came out of the Bacchus Marsh investigation. The investigation looked at the number of neonatal and perinatal deaths that were avoidable. I imagine this Mid Staffordshire issue was basically the same - patients having adverse outcomes that were avoidable. We hear about these; we hear about them in the committee. We have lots of private submissions talking about these sorts of matters as well as members who contact us quite often. I am sure you do in your role. What do you see is the answer? Is it a culture of cover up because everyone is too scared to put their head up because of the punitive and the witch-hunt type approach to this? We are never going to change it, are we?

Dr DAY - No, that is right. Quality and safety has to be driven from the ground up. You cannot enforce it from top down.

If we have a coordinator who says, 'Empower the local areas to report', who is looking at the bigger picture stats, saying, 'There are some indicators from the big picture that may be data error or wobbles in stats but how about we look at that area? There are some signs of concern and then push that down to the clinicians who are keen to run an audit and see if that is real or not' - which is partly what was happening earlier this year. There were some stats coming from the health round table that indicated the mortality rate within the Royal Hobart Hospital was two, pushing three, standard deviations above the norm. Worrying stats.

An investigation by a good quality person, pulling that data, revealed it was probably an anomaly and not real. That took six months to run that process. The clinicians were keen to run it quickly because is it real or is it not? If it is real, there should not be a bad consequence. It should be, 'We have a problem. How do we fix it?'

CHAIR - Is it lack of a mechanism to gain that data?

Dr DAY - No. In our view, it was the central bureaucracy wanting to control the process. I do not know what they were scared of - that if there was a problem, that would be harmful in some way.

CHAIR - Be used in an inappropriate way or some way to discredit the system.

Ms FORREST - Discredit individuals, maybe.

Dr DAY - Yes, or it would be bad in the media. I do not know. Our clinicians wanted to know. If there is a problem, we need to address it and see the causes of that problem.

CHAIR - Stuart, in your submission you talk about hospital demand planning. Basically, it is not sufficient to address the situation in Tasmania. Do you want to expand on that?

Dr DAY - Yes. Many years ago Heather Wellington put a whole lot of facts and figures together, before she came back again for the federal government, predicting where we would be in 2020 or 2025. We know the predictions were all that demand is increasing but we have somehow got ourselves into this theory that, 'If we ignore it, it will all go away. We can do it all in the community'. That has not been the case.

As clinicians, we have probably leveraged most of the easy things to pick off and the tricks to improve efficiencies through the hospital. We are heading towards a zero sum game. It is going to be harder and harder to drive those things. What our emergency department is seeing is progressively more people who need to be there. The cohort is sicker. More of the people who present need to come into hospital.

CHAIR - Possibly more comorbidities in that?

Dr DAY - Yes. We are older, we are sicker, we have more comobidities and we are more successful in the community. We are keeping people alive and functioning for longer with multiple comorbidities.

CHAIR - You say in your submission that the Royal Hobart Hospital is experiencing a 4 per cent rise in demand year on year. What is your gut feeling there? How long do you see this rise continuing before it peaks? There have been various estimations. Do you have a comment?

Dr DAY - I can't give you a stat but we see no evidence it is going to tail off or fall.

CHAIR - It is not just a baby boomer bubble, moving through?

Dr DAY - No. We are doing two things. The baby boomer bubble is ageing. The other is we have more to offer and do more for everybody. The days of you being too unwell or too many problems to have that procedure or treatment do not exist any more. We have a slicker way of

doing it, or a safer way of doing it, so you get that treatment. People utilise more healthcare more often. The combination of those two things is driving up demand.

CHAIR - And the increase in certain conditions I suppose, such as diabetes and the like?

Dr DAY - Yes, sure. In the past, years ago, if you had diabetes you went blind, your legs fell off and you died of a big heart attack. Now we fix your retinas, fix your kidneys, unblock your arteries with stents, and the same with a heart attack. We treat that with a stent the day you have it and -

Ms FORREST - Depending on where you are.

Dr DAY - Depending on where you are. We also control your sugars better and for a lot longer, so you live a lot longer. People are more functional as a result and more well as a result, so that is a good thing, but it is something that society has to address in time.

CHAIR - We have had one submission from a Dr Bryan Walpole who talks about academic medical centres. He has this model of how, particularly for Tasmania, a statewide academic medical centre with perhaps the University of Tasmania medical centre with three campuses, so that recruiting and those sorts of things can happen through one avenue. It also addresses things like the teaching -

Ms FORREST - The joint appointments.

CHAIR - The joint appointments, yes. Have you had an opportunity to either talk with Bryan or are you aware of that?

Dr DAY - No, not recently but the concept of what makes working in a public hospital system attractive is just that. It is that interaction with training the next generation -

CHAIR - It is the mix.

Dr DAY - There is the opportunity for research. Not everybody wants to do research but there are a lot of people that do and the medical student training again and the specialist training colleges processes. That makes working in the public hospital system attractive for specialists and so anything we can do to encourage that enables our recruitment.

CHAIR - He points to the McEwan review in 2016. I do not know whether you are aware of that? One of the senior executives in the National Health and Medical Research Council and he says Alastair McEwan, one of the senior executives of NHMRC, was asked to look into the administrative ranges of quality in Australian hospitals. His recommendation is to establish six or seven academic medical centres around the country, basically talking about a new learning institution. He says there could be a joint appointments board as well so that everything goes through this board. It provides an opportunity to be able to make sure that the gaps are filled where there are service gaps or specialist gaps to deliver certain services and the like.

Dr DAY - There is a lot of positive in that. We still have a size problem, if you like. We are relatively small and when you move up towards Burnie you are very small in the global picture. You do need those interrelated links because you need to be able to perform good quality research and there are plenty of opportunities for good quality research in Tasmania with a relatively stable

population. But you do need all of the support things that go with that. Leveraging Menzies centres and universities, which are distributed - we have medical schools and campuses in all three major hospitals - so leveraging them makes those places attractive.

CHAIR - Do you see then that that might be a way of being able to attract the specialists that are needed in some of those more remote locations to -

Dr DAY - It is a component.

CHAIR - Otherwise how do you entice them?

Dr DAY - It is really difficult. You have a Melbourne and a Sydney growing every couple of years by the size of Launceston. That soaks up a Launceston-worth of specialists every year or two. It is really difficult to attract somebody to come to a regional centre where they are perceived - and a lot of it is perception - to work harder with less support. If you stay in Melbourne or Sydney within two years there's more than enough work because it has grown that big. It is a challenge. The medical profession is talking about this, because it is not unique to Launceston and Burnie; it is outer suburbs; Bendigo and Ballarat have similar problems.

CHAIR - All the regional locations.

Dr DAY - The Northern Territory has plenty of problems. We have to be in the game. The important thing is we are training medical students: local medical students, locally. We have training programs locally often a rotation, but people are seeing in their training processes that this is a viable alternative and they are the future for our more regional and remote places.

CHAIR - To be able to train people properly you have to have accredited centres to be able to do that.

Dr DAY - Indeed.

CHAIR - That has been a bit of an issue. Do you have any comment on that in Tasmania?

Ms FORREST - Can I just rephrase that question slightly, because I was going to ask it myself?

CHAIR - Okay.

Ms FORREST - Why is accreditation important? It would be really good to have that, as that's the crux of it. Why do we need to have it? We lost our psych accreditation at the Royal; hung on by the skin of our teeth with anaesthetics in the north-west just yesterday.

Dr DAY - Yesterday, yes.

Ms FORREST - Fraught, but just interested in why it's important?

Dr DAY - The hospital has a whole series of doctors within it. It has interns straight out of medical school. They have a general training with no particular training program where they get general experience and then they want to move through a program to reach a specialist pathway; from general practice, which is a specialist pathway, through to anaesthetic, surgery, or physicians

or psychiatry. Having those pathways available is really important because it gives doctors within the hospital a pathway that they can achieve.

Ms FORREST - This can be local people you're talking about, local students?

Dr DAY - Yes, that's right. With training you have to move, so you need generally a four to five year broad experience, from both the high end to the more general end of things. The colleges, under the AMC - the Australian Medical Council - that accredits the colleges to accredit their programs, has a defined educational program that delivers specialist training. They come to a hospital and say, are you meeting the standard? Are you offering a good training environment for your future specialists? Are you supervising them appropriately? Do they have the amenities? Are there the support structures to look after them? Is the workload reasonable? And those sorts of things, so there is a balance of education and service delivery.

Tasmania hasn't been, in our opinion, keeping up. We haven't got worse, so to speak, but the standards move on every year in anything that we do and we've just slipped a little bit behind.

CHAIR - Is there any particular area that is causing us the grief?

Dr DAY - Broadly it is across multi-specialities and it is probably as a result of the fact that we've slightly shifted our focus to the service delivery without valuing the education component that's been so important. That's let us slip, to be honest, and a philosophy that it hasn't been as important and had as clear a focus.

Mr FINCH - Have you made this known to the minister?

Dr DAY - Through the correct systems, for instance, 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 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.

Ms FORREST - As I understand it, though, to make the college happy, so to speak, they are having to pay a whole lot more people again to supervise, whereas in some bigger centres you don't have the same high number of supervisors. Is that because we've gone so far backwards that you guys throw everything at it now to make it work? What is the problem?

Dr DAY - In a big department your clinicians have time that isn't direct patient care and so there are a lot of little bits of that time that makes up quite a bit of time. In a small department where you're struggling to deliver the service tomorrow and hoping that the locum is coming the day after, it's difficult to set that time away to keep ahead of the training program. Small departments are always going to struggle with the education and therefore it has to be an absolute focus of the state that we support our small departments to continue their training program. The training program brings a rotation of more senior doctors into a hospital that would otherwise not attract them and that keeps specialists in those hospitals because they have keen people who want to learn and get to the next level. There is plenty of good quality work to be delivered in those places and a different experience that doesn't exist in large tertiary and quaternary centres.

CHAIR - Clinicians have to be respected too, don't they, to have the students wanting to go there to train?

Dr DAY -That's right.

CHAIR - It is important from that perspective. We are over time but we have another question.

Ms FORREST - I want to give Stuart the challenge of taking on a task he does not want to take on as minister for health. Succinctly, what will you do to fix the problems as your key priority? If you were the health minister now, what would you do?

Dr DAY - If I was health minister I'd need a person who can deliver in heading up my THS - and I haven't got that - who is prepared to give me fearless advice and tell it like it is and not sugar-coat it. Leverage your good clinicians on the ground -

Ms FORREST - Empower them too?

Dr DAY - Yes, totally.

Ms FORREST - How would you empower them?

Dr DAY - It comes with rights and responsibilities, but deliver for me and get on. If you can sort this and get it running we will stay out of the way, because there are still those hospital systems and people within them, the administrative people and the clinicians, who can pick up the pieces and get on with it. Then they would need to refocus the more strategic direction that we all want to see happen.

Ms FORREST - As to the patient safety stuff we talked about earlier, clearly the focus of all medical staff is good patient outcomes.

Dr DAY - Yes. As I said, we had three patient safety-focused staffing units within each hospital. We should reinvigorate them, give them the power to deliver locally and coordinate them at a higher level so they can learn from each other.

CHAIR - One final question. Do you see the system at the moment being too politicised? I can probably guess what your answer might be but I am interested to hear it. One party gets in and wants to be the original thinker. Another party gets in and it wants to be the original thinker. Things are pushed and shoved and the long-term focus is possibly not there. Do you have a comment on that?

Dr DAY - We desperately need a longer-term focus, as you suggest, that crosses those political cycles. We are realists. It is a third of the state's budget so it's always going to be in the political arena. We can spend all the state budget if you like if you give it to us, so there is always going to be a tension of what we can deliver. We need a longer-term vision that we stick to, that we do not keep changing. That is an important point. We are not saying throw out the THS system as a whole. Let's just tweak and refocus it, because the last thing our clinicians want is another system change because that just soaks up brain power, energy and time that we don't have. You need that energy, brain power and time to build a hospital in Hobart and deliver services throughout the place.

CHAIR - So it's fair to say there's a fair bit of change fatigue? That has been indicated by some.

Ms FORREST - Don't throw the baby out with the bathwater.

Dr DAY - That's right. We can't do another change, or we would prefer not to.

CHAIR - Thanks very much, Stuart, for coming today to present. We really appreciate that.

Dr DAY - Thank you.

THE WITNESS WITHDREW.

PUBLIC

Dr BASTIAN SEIDEL, PRESIDENT, **Dr JENNY PRESSER**, **Mr MATTHEW RUSH**, CEO, RACGP TASMANIA AND **Dr GEROME WILSON**, GP, LAUNCESTON, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the public hearing of the Government Administration A Subcommittee Inquiry into the Acute Health Services in Tasmania. This is not a government inquiry; this is a Legislative Council committee inquiry, a subcommittee of one of our administrative committees. All evidence taken at the hearing is protected by parliamentary privilege. I remind you that any comments that you make outside of this hearing may not be afforded such privilege. There is a copy of the Information for Witnesses that has been made available to you. Have you all read it and understand its contents?

Messrs SEIDEL, PRESSER, RUSH and WILSON - Yes.

CHAIR - The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available. We will ask that you make, if you wish, opening statements. I am not sure whether one or more of you will, but you will have the opportunity to do that and then we will follow with questions.

Dr SEIDEL - Thank you for the invitation to present at today's subcommittee hearing, which we very much appreciate. I apologise that we did not put a submission to you by the deadline. We have a statement that we can send to you directly, but I will read out our initial statement and then we are ready to answer any of your questions. I am mindful of the time; I understand that the Minister for Health, Mr Ferguson, is presenting after.

CHAIR - You will go to you finish.

Dr SEIDEL - That's on record now. General practice is the foundation of Australia's health care system. GPs and their teams are the most accessed part of the Australian health care service, providing more than 2.8 million Medicare benefit services in Tasmania to just over half a million patients each year. Given the key impact our practice has on health and with Tasmania having one of the worst indices for chronic disease and ageing population in the country, the support of general practice and primary care in delivering and moderating the work log in the acute care sector is absolutely vital and essential.

The failure of successive state and federal governments to invest adequately in general practice has resulted in continued increase in the presentation and expectation of services within the acute care sector. GP-led continuity care offers the Tasmanian health system the best option for easing the weight on our public hospitals. Anything that supports our ailing acute care sector offers support to our patients in general practice.

In our submission, we have developed that, based on the principle that supporting the identified aspects of general practice will bring benefits to patients, funders, the professions and the wider community.

The following three stages are proposed for investing in patient health care to support the Tasmanian acute care sector. First, an annual $50 000 GP innovation payment to support practices in ensuring vulnerable patients do not end up readmitted to hospital. Second, a commitment to fund public non-GP specialist services in all regions, recognising GP backfilling

in the absence of non-GP specialists with appropriate remuneration. Third, commitment to more mental health services, beds and support for GP-led mental health in the community. If time allows, I will go through the three points in more specific detail.

CHAIR - Yes.

Dr SEIDEL - RACGP Tasmania estimates that unexpected or unnecessary re-admission to hospital of general practice patients, post-discharge, costs the Tasmanian health system up to $1.5 million per year. The cost to the public purse for an outpatient consult in a hospital setting is around $150 versus $37.05 for a general practice consultation in the community. This represents a clear saving simply by keeping patients out of hospitals. The costs incurred in unnecessary re-admissions are the result of poor hospital discharge processes, internal systems that conspire against timely provision of discharge information, and lack of commitment from the THS in remediating the problem and proactively moving forward to a more interoperable IT system.

The RACGP has highlighted the issue in meeting with the THS and the minister since 2014 - more than three years. There is compelling evidence that a follow-up consultation to the patient's GP within seven days of discharge is associated with a much lower risk re-admission. We can reduce re-admission rates by 23 per cent but this must be supported by timely provision of discharge information.

RACGP Tasmania proposes GPs be resourced for the provision of an annual GP innovation payment of $50 000 per practice to ensure that patients are not re-admitted unnecessarily. The resourcing of general practice to orchestrate the curating and collation of missing discharge information will allow for GPs to support their most vulnerable patients, maintaining continuity of care for the patient while ensuring patients do not end up back at the hospital.

Second point: commitment to fund public non-GP specialist services in all regions, recognising GP backfilling in the absence of non-GP specialists with appropriate remuneration. Tasmania has four government-funded tertiary hospitals along a stretch of highway, 400 kilometres long. When it comes to provision of specialist services, these hospitals are chronically underresourced. The Department of Health and Human Services lists at least four non-GP medical specialties with waiting times for service of longer than three months, while the waiting time for an urgent gastroenterological clinic procedure is up to 700 days.

At the end of 2016, the public non-GP specialist endocrinology service in Launceston was staffed at 0.3 full-time equivalent. This service is so underresourced that GPs in Launceston received letters in 2016 indicating that there was no capacity for a referral to a public endocrinology in Launceston at the time. That was published in *The Examiner* in February 2017.

This shortfall in specialist referral services leaves the GP no choice but to mange patients in the community - a service with a level of complexity and acuity for which GPs are not funded by the MBS - or to refer patients directly to interstate specialists.

RACGP Tasmania calls on the Tasmanian Government to urgently fund equitable and timely access to all non-GP specialist services in all regions in Tasmania. The immediate up-resourcing of services to decrease the waiting times for Tasmanians is urgently needed. In a state where the vast majority of the population is no more than 50 kilometres from a tertiary care centre - that is the hospital - there should be no reason for Tasmanians to wait for over a year for public specialist assessment and treatment.

Additionally, RACGP Tasmania calls on the Tasmanian Government to commit to providing the same remuneration to support GPs at what non-GP specialists would have received for providing the service or same care, particularly when the GP is supporting a patient in the absence of a non-GP specialist.

Third and final point: commitment to more mental health services, beds and support for GP-led mental health in the community. For most Australians, and Tasmanians, general practice is considered the first port of call when they need to access the Australian health care system, regardless of where they end up in that system. A patient's GP is usually the first person they would consult for their mental health care. According to the Bettering Evaluation of Care in Health - or BECH - survey, an estimated 11.7 per cent of all GP consultations were mental health-related in 2011-12. Furthermore, in the same year GPs and other medical practitioners provided more than $2.1 million MBS-subsidised mental health services. While RACGP Tasmania believes that the majority of mental health issues should be managed within the community and expressly mediated by the patient's chosen GP, there is a desperate need for timely and effective tertiary mental health care in the public landscape.

It is almost a cliché in Tasmania to link shortfalls in the THS with dysfunctional or non-existent mental health services. With one in eight GP consultations, up to 4000 consultations in Tasmania annually directly relate to mental health. GPs backfill a significant number of services that would cripple the THS were they not managed in the community by their GP. RACGP Tasmania again calls on the Tasmanian Government to act immediately to increase the capacity of public mental services and support the work that GPs undertake in the community. Further, we call on the Tasmanian Government to resource primary care mental health services and the GPs who will staff them with appropriate state-funded resources and remuneration.

CHAIR - Thank you very much for that.

Mr FINCH - Bastian, the $50 000 - you call it innovation?

Dr SEIDEL - Yes, that is right.

Mr FINCH - Is that innovative for Australia? Is there anywhere else that is offering this sort of stipend to GPs?

Dr SEIDEL - Yes, it currently seems to happen in state governments on the mainland. I understand that the New South Wales state government is in discussions with the RACGP and the AMA to support general practice systems to provide more services in the community, in particular with the view of avoiding admissions to the hospitals and readmissions to hospitals as well. We know non-tertiary care institutions such as hospitals are extraordinarily expensive to run. The federal government spends $49.8 billion every year on public hospitals, there is another $16-odd billion that the states are chipping in, $11 billion is coming to private hospitals and the taxpayer subsidises that with $6.5 billion via the private health insurance rebate.

We are hearing here in Tasmania that a third of the total budget is ending up in health care. I think the projections for South Australia were 50 per cent of the total budget. This is not sustainable. I believe that in Tasmania we are quite lucky, because if we compare the funding or spending on health compared to tax revenue, Tasmania has the lowest proportion compared to all other states in Australia, so there is plenty of money left that can be put into the health care

system. We know, based on experience internationally and from interstate, that the health dollar goes further if you put it into prevention and general practice. We need to move away from the expensive treatment of disease towards keeping patients healthy in the community.

That is why we cannot do the things we have been doing here in Tasmania over the last decades trying to prop up the hospital system. There has to be a rethink about how we keep people out of hospital and if they are in hospital, how we get them quickly back into the community and make sure they are not being readmitted within a very short period of time.

Mr FINCH - Bastian, clarify for me - with the New South Wales example you gave, are you saying they are in discussions or that is in place?

Dr SEIDEL - No, they are in discussions now. There is some funding that has been made available, I believe, from the New South Wales government via the primary health networks in order to run projects to prevent readmission to hospital and to have enhanced services in the community. We are aware, for example, that a couple of years ago in Queensland a public hospital service outsourced their diabetes care into the community. It was completely run by GPs in the community because they realised the health outcomes were exactly the same and they could do it for a fraction of the cost. There was a commitment of subsidiarity, meaning that the lowest organisation that can do the job for the patient is doing the job, and there was no escalation of that put in place. It worked extremely well in Queensland and I believe that is still the standard care for public diabetes services.

Ms FORREST - On that point, how is that to be funded? A lot of general practice and primary health is funded from the Commonwealth. Are you suggesting it be a Commonwealth payment or a state payment?

Dr SEIDEL - Look, we are in it together, quite frankly. As to this idea that general practice is only funded by the federal government but hospitals are funded by federal a bit and the state a bit as well, I think we have been sold out in general practice. There was always the assumption that general practice was only ever going to be funded by the federal government, but the state government should have an interest in funding general practice because we are preventing hospital admissions that are costing the taxpayer even more. It is a no-brainer to say we can no longer be penny-wise but pound-foolish and that is why it makes senses to make some payment to general practice systems and GPs to keep the community healthy.

Ms FORREST - Keep people out of the hospitals.

Dr WILSON - The diabetes clinic is practical example here in Launceston. We've got a GP with us, Gary Kilov, who has type 1 diabetes himself and now exclusively runs a diabetes clinic within the health hub. He has a dietician, an allied health professional, a diabetic educator that no patient wants to pay for, and an exercise physiologist. We took a model to the Health department and said if you can't fund from 2016 any diabetics care, we have someone who goes around the world talking about diabetes and he is a much cheaper model to run.

To make the model sustainable for us - we've already got the team, we've got the building and are busy - the difference was who can afford to do it. The diabetics who can afford a gap, like you or me who are working, come to our service. There is a huge unmet need for the people most at risk and most disadvantaged.

Regarding the $37 that Bastian mentioned to see Gary, we were after the top-up of the difference between the $25 gap for those patients on a concession card or pension card and then for the diabetic educator that people struggle with paying for; there is no funding for that through Medicare. It even got to the point where we said, 'Can you say to the referrals that have come in, here is a private option if you can pay', but they wouldn't even forward on referrals to us because they didn't want to be seen as favouring one clinic over another. It is really hard to innovate within the public sector as it is, whereas people outside are looking at different ways of doing it. As mentioned before by Stuart, if you can look at partnerships where there is a bit of Commonwealth money, a bit of general practice, a bit of patient and a bit of state, it makes a lot more sense.

Ms FORREST - Surely this is a matter for COAG. Because there is a crossover and there needs to be a crossover between federal and state, it needs to be something the Health minister would take to COAG. You said you took a proposal to the Health minister.

Dr WILSON - Yes, he has met with us twice about it; you can ask him about it afterwards. There are lots of different innovative models like this and we have to have a bit of a rethink. Like Bastian was saying, this is an example of back-filling our patient services. If we keep doing things the way we are doing in treating acute disease, one really sort of dynamic model could be asking why we need to have outpatient clinics at hospital at all. That encourages segregated silo care. When you need an intervention or specialist care you go to hospital, but in Tasmania the majority of our specialists all work in private and public. Stuart and I run a GP private anaesthetists; I assist the surgeon and work across public and private.

What I would say to the orthopaedic surgeons is that rather than run the most inefficient outpatient service where you get 20 per cent to 30 per cent of people not turning up and surgeons saying they want to see more people, rethink the model and put all that money into a bucket and have these different clinics and run more in the community. If it is being run in the community and they are seeing the same person ongoing and then bringing the training people from the hospital into the community so they get more experience, why not take a more radical look at ways of running a hospital? Hospital is for when you need to be admitted for a procedure. Then all the rest of the information and care is done in the community where they are a lot less likely to get lost through the cracks in the system. There are different ways of dealing with these big problems.

Mr FINCH - Gerome, for the sake of *Hansard*, Gary who did you say?

Ms FORREST - Kilov - he is a Burnie doctor.

Dr WILSON - Yes, originally from Burnie. I would say it should be more a traditional model of using the medications and not just focused solely on the diet like Gary is and working within that sort of model. Gary cheekily said to me in surgery the other day, 'I do send some people your way just so I don't get into trouble for sending them all to Nutrition for Life and things like that.'. We have quite a good close-knit community but there is different innovation that really gets stifled when it comes to working with the public health sector.

Dr SEIDEL - It is an excellent point Gerome makes because patients do not want to go to hospital. They want to stay with their GP in their community. They want to be in the practice where they know the doctors there. They do not want to be outsourced to a potentially junior

doctor they have never met before and they have to tell their whole life story again. It is the continuity of care where there will be saving lives, saving admission rates as well.

If that can be delivered in a community setting at a very reasonable cost, and the cost is certainly less compared to what the hospital environment would be, then why not encourage that? We know the status quo is not going to be sustainable here in Tasmania.

CHAIR - It basically supports preventative health, doesn't it?

Dr SEIDEL - Yes.

Dr WILSON - The other example is that GPs are a very cheap workforce. We have been banging our head against the wall in the north-west and the north for 10 years, and we just cannot attract the endocrinologists out of Sydney where they have spent 12 years of their life training. GPs like Gary, who sub-specialise within general practice, are a lot more mobile, affordable and in the community already. That is what he is talking about with backfilling.

The same thing goes in Queensland. They are using a lot of GPs to do endoscopies and colonoscopies. We have a wait list here of over 700 days. For the low-risk easy ones when you have a positive -

Ms FORREST - Seven hundred days for colonoscopies and endoscopies?

Dr WILSON - Yes, whereas if you worked with some innovative GPs where you have a gastroenterologist at the top of the tree that supervises and says, 'That one looks straightforward. You do it and if you get stuck, call me,' and then they do the tricky ones and the top-end ones, and it is a really integrated service between the public and private. There are many ways to solve these problems.

The way the public health service works at the moment, you have to do a budget submission, know how to write a paper, put in the money, and then it goes out to tender. With the diabetes they said it was about a two to two-and-a-half year process to actually get the service in place. There is a constant problem in the state health service of 'program-it is', where they will come up with a program, fund it for one, two or three years, and we just get change and program fatigue. Then when a service is available, it is not often utilised because it is only there for a while and people say, 'Why bother about it?' We need long-term commitments.

Ms FORREST - Innovation moves quicker than two years?

Dr WILSON - It does.

Ms FORREST - That is why it is called innovation.

CHAIR - Yes.

Dr SEIDEL - Let us imagine the opportunities if communities can decide what actually the needs of the patients are, together with their doctor. We know that 85 per cent of Tasmanians are seeing their GP at least once a year anyway. We know what the community expectations are, we know what the shortcomings are. They might be different in Launceston compared to Hobart, but who knows? The principle is the same.

We are looking for a modest amount, $50 000 every year. We have over 200 practices here, so yes, it is going to be $10 million, but put it into perspective. We have over 500 000 people living in Tasmania. We know that way over 85 per cent see their GP at least once a year. That is $20 per Tasmanian per year, it is five cents a day.

Compared to what we spend on other services - like the ambulance service, I think is funded with $54 million every year. Remember again, when it comes to health funding in Tasmania, its proportion of tax revenue is the lowest compared to all other states. The money is certainly there. Where do we put it for it to be the best bang for your buck? For five cents a day per person in Tasmania, where there is an obvious shortfall, otherwise we would not have the inquiry, what do we have to lose? The answer is not much.

Mr FINCH - Can I just drill down into the poor discharge processes? You say the hospital does not send the information back to you. If you could just explain how that works and how it should work?

Dr PRESSER - For example, I might find out that a young person in my care at headspace has been admitted to the hospital with an overdose. The first time I find it, it will most likely be the pathology results. I will be named on the pathology form as their GP, and in my inbox will pop up a paracetamol result. I will be like, 'My goodness, that person must be in hospital with a paracetamol overdose'.

The pathology will come in the very next day, but I will not have received any information from the hospital that that person has been admitted or what is going on. Often then, the day after or the day after that, I will get a single page saying that they have been admitted, but nothing about it. We are always on the phone asking, 'Are they still there? Have you actually discharged them,' because the information about when they have been discharged, the discharge summary often will take a week, two weeks.

That is not a safe interval for someone to have been discharged from the hospital after an overdose to follow up with their GP. They are a young person, they are not well with their mental health. That type of responsibility, to be able to do that adequately we need to be quickly following them up and making sure they're okay. If you don't know when they're being discharged that is just not safe.

CHAIR - There's no privacy issue here, is there, with hospitals providing you with information for a patient?

Dr PRESSER - Yes, it's an ongoing patient of mine.

CHAIR - It's not a privacy issue is it?

Dr PRESSER -No, the young person has identified us as their GP service and the hospital would normally provide that information.

Dr WILSON - On that model some states are far better at the recordkeeping of this. I'm involved with a software company that provides it and they can tell you exactly the stats on how poor they are and how little people get them completed on time and actually don't have anything to do with their care that are writing a letter some time later. Somewhere like Queensland in the

last 12 months, which has taken a more innovative approach, saying we've got a proper digital medical record rather than a pseudo one as we have in Tasmania, and giving all registered GPs access to that.

If they get a pathology result or they know their patient has been in hospital they can actually log in and have a look at everything they need to, to help with that patient's continuity of care. The first step is having the discharge summary all nicely summarised, but if you don't have that you have the back up of logging into a secure IT service to then get the information that you need.

Ms FORREST - One thing we did hear about is that there are some GPs who won't use electronic records, won't use emails and things like that, which makes it more difficult because snails get lost these days.

Dr BASTIAN - I do apologise. I think over 95 per cent of all GPs in Tasmania have electronic records.

CHAIR - Over 95 per cent.

Dr BASTIAN - That's correct. It is a non-issue in Tasmania, quite frankly.

Mr RUSH - Of that 95 per cent the vast majority of them have one of the three major packages. The reality is the actual understanding of the IT is very simple.

Ms FORREST - Packages that talk to each other.

Dr BASTIAN - The difficulty is, if I don't know about anything that comes out of the hospital and the patient shows up and I have no information it is actually not very safe to look after the patient. We have to make a decision, are we in a position to chase that information or do we send the patient back to hospital? Our concern is that we are going to send the patient back to hospital. In my practice, and I guess the same for Gerome and the same for Jenny, there is probably one patient a week that we are sending back. That is 50 patients -

Ms FORREST - Because you haven't got the information.

Dr BASTIAN - Because we don't have the information. It is 200 practices: one patient every week goes back because of no information, so that is 10 000 patients, 10 000 readmissions. The cost of that can be entirely reduced by communicating properly.

Ms FORREST - Do you have a ballpark figure for how much that costs to send those 10 000 patients back?

Dr BASTIAN - As we say at least $1.5 million and that is only if they are being seen in A&E. That is just the presentation, never mind that they probably don't know what's going on either, because they might not have any records or can't access them and then the whole thing starts again.

Mr FINCH - The question is then, how does the system change to best serve the patient and the GP? What should be put in place?

Dr PRESSER - One of the big things that has made a difference in Queensland has been a key performance indicator for the hospitals to provide adequate timely discharge information.

Mr FINCH - To GPs?

Dr PRESSER -To GPs. Within 48 hours - even 48 hours you could argue isn't best practice, but it is better than it is now - that information must be sent to the GP as one of their KPIs. That is something that could be done easily. It would save lives.

Mr RUSH - Interestingly enough from the point of view of how easy it is to change, purely because of the tender process in Launceston where pathology in the LGH became private pathology people can now get immediate access to pathology records coming in, which they couldn't before.

CHAIR - That's interesting.

Dr BASTIAN - Gerome makes a very good point where you can think, when we are referring the patient we are doing the letter at the point of care and there is no reason that cannot happen from the hospital when they are being discharged. It is actually a clinical handover. It has to be timely and there is no reason why you cannot compile a letter at the time of discharge. If that doesn't work for whatever reason, because you are short staffed give us the opportunity to access hospital records. I think it is the Gold Coast that is using Viewer and it could be easily done. We have just over 550 registered GPs in Tasmania we should all be given access to have a look at public hospital records.

CHAIR - Was that 550?

Dr BASTIAN - Just over 550. That could be easily done. The software is out there, it is being used and it is safe. We GPs could be audited so there is no inappropriate access to hospital records, but we would have information that is going to make a difference to our patients.

CHAIR - It could be that you have access to just the patients that you actually have.

Mr FINCH - Can I drill down, Bastian, on something you said about gastroenterology. You said that 700 days could be the delay in getting it done in the public system with the public specialist. Clarify for me a 'non-GP specialist', please.

Dr SEIDEL - A non-GP specialist covers all medical specialists who are not GPs. It could be a gastroenterologist, a neurologist, a general physician or a general surgeon.

Mr FINCH - Who do not do GP work?

Dr SEIDEL - That is correct.

Dr PRESSER - Rather than saying, a specialist and then a GP, a GP is a specialist, a general practice specialist, we are referring to the other specialties as non-GP; just the other way around.

Ms FORREST - Would you be confident that access to the hospital clinical records would give you the current discharge medications, for example? Sometimes they can change on discharge.

Dr PRESSER - Discharge medications might be best coming with the order to the pharmacy. Some hospital systems, I think in Queensland, the order to the pharmacy goes with the summary to the GP just as the discharge medications do, so that is accurate.

Ms FORREST - That comes separately?

Dr PRESSER - Yes. They will get it first, before they will get the actual discharge letter within 48 hours.

CHAIR - Having access to the medical record, from what I am hearing, you say it is a pseudo-medical record. I have been in the system for a long time - 20 years in health in ICT - so understand all of this. It may be a situation where it does not have the up-to-date information yet because it has not been updated from notes.

Dr SEIDEL - You are right, it is difficult. Jenny gave the example of the paracetamol overdose. Wouldn't it be nice if, when she gets a lab result and does not know what is going on, that she could go back into the medical record of the hospital and see that the patient was admitted and what the treatment was? At least it would give her a better idea. If she could do that any time: she does not have to call anybody and then be put through the paces of getting some information. It is not ideal but it would be better than nothing whilst we work on a better solution.

CHAIR - One question about mental health patients presenting in emergency departments. At the moment we are having a significant wait. You mentioned something about mental health services in the community and how it could improve the situation at the hospital. Can you expand more on that?

Dr SEIDEL - I would like to refer the question to Jenny because she works in the mental health area in community.

Dr PRESSER - GPs do the majority of mental health care in Australia. There is a perception that GPs do the mild cases but we are doing everything that is not being currently seen by psychiatrists. That is not mild to moderate. The gap is where we get to the point that we need specialist advice to keep the patient out of hospital. That is often not accessible.

For example, I was talking to a colleague from Launceston at lunch. They do not have a psychiatrist in the public system they can ring for specialist advice. You get through to the mental health help line but you could not pick up the phone to ask the surgeon advice about the patient that you are seeing about medication. How straightforward would that be to provide specialist advice to GPs so they can help keep their patient out of the system?

In certain cases, it is a medical emergency, like a heart attack. If someone is acutely psychotic, they are not safe to be in the community, they cannot look after themselves, they are at a risk to themselves, and they need admission to keep them safe while that improves. Having to battle to get an acutely unwell person into the public system is such a risk to the patient.

For example, I was involved with a 17-year-old young man who had his first presentation of psychosis. Because he was 17 that could be a paediatric admission but he had previously been seen and kicked over rubbish bin and made a bit of a ruckus. Because he was developing psychosis, the paediatric team was not able to admit him to the paediatric ward because of that

behaviour. The adult team could not see him because he was 17. We are left, trying to manage this young man who is very unwell, in the community. It was such a risk to him. After some time we found that the uncle he was living with was not a blood relative. Thank goodness, that person was very kindly disposed and a great help to this young man, but that uncle could have been anyone for this young man who was not able to think for himself.

As a GP I am not resourced to care adequately for someone in that acute care situation. There are too many holes at the moment for people that are acutely unwell, but we can manage the rest if we are adequately resourced for that.

CHAIR - Part of the solution then to that circumstance?

Dr PRESSER - At the moment everyone is saying that there are not enough beds and psychiatrists all over the state to treat our current needs.

CHAIR - Are you seeing a trend in what is causing this ballooning? Maybe ballooning is not the right word.

Dr PRESSER - I am not sure it is ballooning. My understanding is that the number of beds was reduced a few years ago. Since then we have had more of a shortage. I am not necessarily seeing an increase in numbers presenting at that really unwell end. There are more young people with mental distress that we can manage adequately in primary care, I think.

CHAIR - What do you see that is causing the mental distress? Is it their general family circumstances? Is it the fact that they are on ice? Do you have a handle on that?

Dr PRESSER - It is complex. There seems to be factors that are cultural and societal, such as young people being less able to access adequate employment and education. Independence is definitely a key factor. More access to and use of drugs and alcohol is a precipitant to mental ill health, but usually is secondary to the lack of opportunity for young people in Tasmania.

CHAIR - We will take one final question. The minister has just arrived to talk with us.

Ms FORREST - I talk to a lot of my GPs around my electorate. It is always a challenge in the regional areas. Some of them are provided through organisations like Ochre and that sort of thing. What I am hearing is that the real challenges for GPs is lack of access to non-GP specialists when they need them. On the north-west coast, for example, I understand that there is about a 14-month wait to see a respiratory physician. We have the endoscopy wait. A fresh rectal bleed and a patient waits eight months, so by the time they get there for a colonoscopy they have metastases. That cannot be very good at all. There are no public rheumatologists. Endocrinology - there is an 18-months to two-year wait. Pain specialists - there are not any.

Surely people with chronic need to be seen in their local area and not have to travel to Hobart from Marrawah or Strahan. All these non-GP specialist requirements have been pushed onto the GP, who is not a specialist in that area. It increases the GPs work load who is not being paid appropriately because it is not covered under the MBS. What do we need in this state?

Bastian, I have just made you the health minister for today. Stuart has had his turn and he has given up. He failed.

CHAIR - It is a great relief for those in the corner.

Ms FORREST - There is a revolving door for health ministers. Where do we start? What do we do? This is creating huge problems.

Dr SEIDEL - The concern you are raising is quite pointed. We are currently dealing with the perception of the health system in Tasmania. It is not an actual system. If GPs were not doing what they are doing in our communities, the whole thing would be falling apart. It would be a complete disaster for Tasmanian communities. Quite frankly people would be leaving the state if they could not access appropriate health services. There has to be a re-think. We have to be re-thinking away from focusing on the expensive treatment of disease in a tertiary care system. It has to be thinking towards maintaining health in the community. We have to keep people healthy. That should be the focus; therefore, we need to be talking about prevention first and foremost.

There is doubt that we need to fix the many problems that require hospital attendance. But re-thinking needs to start. A good example is influenza waves when they are coming up. Every year the Tasmanian hospital system is falling apart because people have the flu in winter. Every year it is predictable. If you had a hospital system that was running at 85 per cent capacity with nothing else to do, that would be fabulous. We could just send patients in and it would be great education and training exercise, but we are running at capacity on a good day so those bad days are predictable. We need to focus on prevention, which is funding influenza vaccines for everybody because we have no other choice in preventing influenza.

There has to be a rethink on how we can keep people healthy rather than just wondering why they are sick and how we can treat them when they are all sick. Certainly the hospitals in Tasmania are not the solution. We have tried and we have failed so we have to have a grown-up discussion where we can take the health of this state to the next level, and that is going to be focusing on community care.

Ms FORREST - And innovative models of care.

Dr WILSON - I think to your point in the rural areas, the GPs are the only ones there providing the care. As a GP I have seen the changes in the short time I have been in the career. I have an interest in sports medicine, Gary in diabetes, and Jenny in mental health. If we had a good training pathway and a funded program for GPs to say, 'You can spend some time with gastroenterologists, learn how to scope and then we will give you a job in Burnie and Mersey employed in that area', GPs are the most likely people work in a community because they are already there. Their colleagues are going to be happy to refer to them and there are good pathways so that when it is beyond the GP's scope it goes to the specialist colleagues and it is a cohesive thing.

Ms FORREST - Isn't there a bit of turf protection that goes on there, though?

Dr WILSON - Not in that regard. If you have a patient who needs a colonoscopy and it's an eight-month wait, if you're referring to the GP who is based in the community and only does two days a week of seeing patients pre-scope and a day a week of scoping, there is going to be none of that turf protection because they're getting paid from the state government providing the service and are seeing them for their colonoscopy rather than for all their other things.

Dr PRESSER - It is probably that those pathways don't exist at the moment and it is that difficulty with innovation that we were discussing.

Dr WILSON - If I trained as a GP endoscopist I'd have no job in Tasmania, whereas other states have those pathways involved, have embraced GPs who are quicker to train and are often happier to go rural, so that is one aspect of it.

CHAIR - One final question and then we will have to cut of there.

Mr FINCH - The faculty manager, Robert Rush, is dying to get a word in there. I was wondering if you could tell us the number of GPs in Tasmania? How are we situated? Some years ago it was very hard to get a GP booking in some of the major centres because they had enough client base. Do we have enough? Are we filled up, or do we need more to come to Tasmania?

Mr RUSH - The number of practising GP members of the RACGP, which is about 95 per cent of GPs across the country, is 580. We have another 150 or so in Tasmania. The numbers are very good. It is safe to say that the perception that you can't get in to see your GP is actually a perception of want rather than need. The RACGP standards have risen in general practice where there is a requirement that you see a GP in a timely fashion. It may not necessarily be the face that you want to see, but the practice you go to will look after your GP needs. If there is an actual urgent need to see a GP, you will be seen. There is absolutely no reason why someone should wait two weeks to see a GP unless they want to see a specific person.

CHAIR - Thank you very much for taking the time to come in and present to us. We really appreciate that.

Drs SEIDEL and WILSON, Mr RUSH and Ms PRESSER - Thank you.

THE WITNESSES WITHDREW.

The Hon. MICHAEL FERGUSON, MINISTER FOR HEALTH, WAS CALLED AND EXAMINED.

CHAIR - Minister, I am pretty sure you are aware that this is the Legislative Council Government Administration A subcommittee inquiry into acute health services in Tasmania. I do not have to deal with parliamentary privilege because that goes without saying in your role. You probably have an opening statement to make.

Mr FERGUSON - I do, yes.

CHAIR - Then we will throw to questions. Of course there is the opportunity for in-camera evidence if necessary. We can discuss that if it gets to that point. Over to you to make your lead-in statement.

Mr FERGUSON - Thank you, Chair and members of the committee. I am very pleased to be here and thanks for the invitation. I know that in part this is an opportunity to speak to the submission I made and no doubt questions of particular topical interest that have developed in your minds as the subcommittee's inquiry has progressed.

I would like to make an opening statement and then go to the subjects you are interested in.

The Government certainly believes that every Tasmanian deserves to have access to the best possible health system and health services available. That is a belief I believe we can show has been really at the heart of the Tasmanian Government's record as a manager of health, as a manager of health reform, but importantly as well, the investments that we've made, including extra beds and hospital staff to support our community.

We've proven that we genuinely want to make a difference in people's lives. We have made some very important improvements, in many cases overdue improvements, into Tasmania's health care system with an increase in frontline hospital staff of more than 300 full-time equivalent staff in the Tasmanian Health Service. This is a record investment in health of more than $7 billion, more than $1.3 billion over the budget four-year period compared to the previous government's last four-year budget.

I noted as well that there have been some claims that have been made by a number of people that 2014 budget strategies led to current pressures in our health system. I put forward the view that they are demonstrably not correct statements and not supported by the facts. What we've done is purposefully targeted backline efficiencies. In part they have been connected with our more appropriate system for our small state of amalgamating the three former THOs into a single Tasmanian Health Service.

Also during 2014-15, which was our first budget financial year, we maintained the number of doctors and nurses, increased bed numbers and even admitted more patients through the emergency departments. The elective surgery waiting list has been a singular success story for this government and for our dedicated staff who have made this possible. Elective surgery waiting lists are now at record lows. More important than the absolute number of the waiting list there are significant reductions in the time that Tasmanians wait for their surgery. The outlook for a person joining the elective surgery waiting list today is a much brighter one than a number of years ago. There are also improvements to emergency care, mental health services and, vitally, our emergency ambulance services.

With all of the positives there is also an acknowledgment, Chair and committee members, that we understand that there is no doubt that for many Tasmanians what they experience at Tasmanian hospitals is not necessarily ideal, nor as good as it gets. We say in many cases when we see people waiting too long for care, even with the improvements that we've seen, that it's not acceptable and we want to continue to improve and to do better.

Just for a matter of personal recordkeeping, I want to make a statement as well that we've never declared the system fixed. We've acknowledged that with improvements they should be made known to the community, supported and indeed congratulating the staff who have made that happen, but we've never claimed that the health system is fixed. That is where we want to get to. Too many people do wait too long in emergency departments. At times people wait too long for outpatient services, like some of the evidence that I've just been listening to from the College of GPs.

Despite big improvements, more staff and more beds being opened we are still not treating everybody within the clinically appropriate time frames that we should be and where we need to aim. While there have been gains, we need to continue to improve the waiting times. That can be achieved through a combination of genuine reform efforts, listening to clinicians, collaborating on solutions and as government is able to provide the financial resources to do it.

It is important to recognise that some of those pressures are as a result of increased demand, not as a lack of investment. I want to say to this committee that we can and we will do better in the future. Our commitment to improving Tasmania's health system has already been demonstrated. We won't be backing away from continuing the job that we've started. The runs are on the board including, I think I can say, in each of your respective communities of interest - north, south and north-west. We've been able to tackle some of the challenges that have been staring governments in the face for years, and sometimes decades.

As a result of working very closely with health staff, management, health planning staff, but crucially the community itself and clinicians through a very open and extensive consultation process that got us to the point of having a white paper, that is now the shared vision for our state.

I put forward the view, quite humbly, that I don't think that previous health ministers have been able to make that claim. That we actually now have a road map for significant improvement for the way that health services are planned and delivered, and no doubt we need to continue that effort of collaborating and listening, and responding.

I thank the committee for what you are doing for this inquiry. I have seen this as a valuable opportunity to put forward our Government's submissions and points of view on issues that are raised but also to listen and anticipate any report findings that might help further inform what we can do to continue to give Tasmanians the health service they deserve.

CHAIR - Thank you very much, minister. There were a number of areas we wanted some responses from you on. I will go to the issue that seems to be coming forward more and more often, and that is the model under which the acute health services delivery works - or doesn't work, is probably more the point - in Tasmania. There needs to be greater decision-making at individual hospital levels. The one health service model, that fine and it is a great aspiration, but it is not working. It is causing difficulties for clinicians within the system with decision-making not being at a single point and having to be outside in the THS upper executive area.

Do you have any comments on that? Are you looking to revisit that to try to improve the situation that is out there and from what we have heard, is causing significant frustration and impacting on staff morale, all sorts of issues that are arising from that model that is being employed at the moment?

Mr FERGUSON - Thanks for the question. I described this recently publicly, and I think it was in parliament, where I was describing that we have been through significant change and reform. We are pleased there has been no claim by any health stakeholder group that we should move back from the statewide one health system. There have been no calls from any serious organisations that we should return to three regions. That is very pleasing.

Where we have seen evidence of some growing pains or some work, as we have brought the three THOs into one, inevitably there would be challenges. My first appearance at budget Estimates with you, Chair, talked about the fact that we are going to need to work through this, recognising there will be challenges. The Government has recognised there have been challenges with local governance. It is fair for me to say to you that since this committee commenced its work, the Government has moved on this. One of the stakeholder organisations, the AMA Tasmania, called for local governance to be more formally instituted at the local level. I believe other medical staff associations have had the same sort of feedback. We have listened to that feedback and while it is still a work in progress, we are already seeing that being rolled out.

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

CHAIR - Minister, we heard today from the AMA that they have lost confidence in the chief executive of the THS. That is a fairly heavy concern for them to be voicing. That is not the need to just fiddle with bits; it is to address it right at the top. They must be very concerned if they are coming out saying that.

Mr FERGUSON - I do not disagree that it is a concern if an organisation like AMA Tasmania makes a statement like that. I am not going to speak for the AMA but my understanding is they have expressed a want of confidence in the chief executive officer, just as they did the previous chief executive officer. We need to be recognising that where there have been legitimate and worthy calls for a continual refinement to the way governance works, we are open and willing to do that. We have done that and we now have a functioning local executive in place at the Royal Hobart Hospital which was not the case at the beginning of this year. Work towards the same outcome is under way in the north.

CHAIR - …I don't think this frustration is just with the Royal, though, I think it's across the board. It is coming forward that it is a general issue about how decisions are being made and how it is affecting delivery of acute health services on the ground at the coalface and where clinicians are simply being hampered by the system and that is a concern.

Mr FERGUSON - I'm acknowledging the concern.

CHAIR - How can you give us a bit hope that this is going to be addressed and addressed effectively, is the question?

Mr FERGUSON - The Government has acknowledged that concern and has even to a fair degree agreed with it, and has for that reason moved on this. It's disappointing if when people make statements that they're not happy with governance or they're not satisfied with the statewide executive process that they should also be letting you know that progress is being made on this, in fact, in many cases in consultation with those very organisations.

I don't seek to be critical here, but I make the point it's about a balancing effort here, because if we do genuinely believe in having one health system then we can't completely abandon some statewide planning. At the same time, the Government has taken the view that operational decisions, things that affect clinicians on the ground and the way that services are provided, for example, in a local hospital, then those decisions are often best made at the local level. We are moving on this. The Royal is further advanced along that journey than the north, but that's where we saw the greatest need.

CHAIR - How are you moving on this? What are you implementing to improve the situation? Can you outline that for us, please?

Mr FERGUSON - I can in broad terms and perhaps if that's helpful I can supplement that with some more detail later. In broad terms, we have a functioning Tasmanian Health Service executive. We have streams that have been developed of services by that executive, with the support of its governing council. That has been consulted at the local level as well as to how it can be achieved to have local management teams in place in each region. As I have said, the Royal Hobart Hospital now has that in place. People have now been employed specifically for those respective roles and it is working, and it's providing solutions on a daily basis when, for example, there might be a patient bed flow issue or some other local issue that needs to be resolved.

Ms FORREST - Just on the local issues, whether it be whichever hospital it's in, I know only the Royal has it at this stage, but things like a key specialist resigns and the decision, currently as I understand it, to replace that person needs to go all the way up to the top of the tree. Clearly if that person was engaged and working a fulltime load before they resigned then you would think that they would still be needed, unless you've taken out a surgeon as well or something, if it was an anaesthetist, for example. You say it is working. What sort of decisions are able to be made down at that lower level, the more grassroots level?

The argument has been that the THS executive should be making high level strategy, overall policy decisions, managing HR, IT policies sort of levels, but not the local operational level management and administrative decisions, at the local level, where solutions are often found by the clinicians working there. Can you talk us through what decision-making power there is at each level here?

Mr FERGUSON - Executive government works through the Department of Health, together with the Tasmanian Health Service, each of which are government agencies to deliver their respective roles. As we have it under legislation, all decisions - every decision - of the THS in the end must be accountably taken by the governing council and the CEO. That is how it works. There has been an increasing move towards - even though we've moved to one health system, there has been an increasing appetite to provide and empower local governance at the local level.

You've asked me about what kinds of decisions, perhaps I might take that on notice to give you some more detail. In broad terms, we need to ensure that the white paper is progressively

being implemented, which is an ambitious document that sets out service improvement. We want to be confident - and I hope that you on your side of the table also would want to be confident - that when employment decisions are being made that they are more or less in tune with the direction of the white paper, ensuring that the services are provided mindful of what the whole state needs, not just one local area.

No doubt, if a surgeon, in your example, resigned and ought to be replaced, of course those decisions do sit at the local level. There may well be some accountability processes at a higher level to ensure that people work within their budgets or ensure that those new employment decisions are mindful.

I will give you an example. A specialist, for example, at the Royal Hobart Hospital that needs to be employed, when you are employing a new one, you would want to be mindful that they were going to work well with the local team. Equally, to be able to ensure that they are part of a - ensuring that where there are other areas, like the north and north-west that are not well served in that speciality, that there would be a view as to how they can support that as well. Decisions are made at the local level, but as with all of us in life, including me, we are often answerable to, and are accountable to, our employer.

CHAIR - Just dealing with this a little bit further, the THS model, if you like, arose from the purchaser provider model so that there was that separation. Some would say that that same model of purchaser provider existed under the old DHHS model as well, meaning that the THS upper level component really was not necessary. Can you give an argument as to why that still should exist today as opposed to simply being encompassed within the service of the DHHS service, the department itself, rather than having this board and the THS -

Ms FORREST - A separate statutory authority.

CHAIR - a separate statutory authority?

Mr FERGUSON - I am not legally expert in this, but I can say that I have had a look at it and the Government certainly had a look at this during our early time in office when we considered whether or not three THOs should continue, or if the state should take the decision to move to a single organisation. The legislation provides for the current arrangements where there is a split between the purchaser and the provider.

In itself that relationship begins to lay out the kind of statewide policies that then get adapted in the THS or reflected in the THS. I am not sure I would agree with you. I might have to get some advice as to whether that existed previously when it was just only the DHHS. If we can ever improve in health, the Government has a track record, we will always listen and we will always be willing to adapt to a changing environment, or to a maturing of the system to ensure that we make good decisions that provide improved health services, cutting down waiting lists, and ensure that clinicians feel valued. Whoever it was - I think it was you, Ms Forrest, on morale - morale is vitally important. I want to support staff feeling valued and listened to as part of solutions for our state.

CHAIR - I am pretty sure it did exist. I spent 20 years in the ICT area of health. I am pretty sure it did exist. I think it was confirmed today by one of the witnesses, that that was the case. We will stand to be corrected if you find otherwise.

Mr FINCH - Minister, you mentioned one of your organisations that you work with, the AMA. How would you view your relationship with the AMA in the work that you do as minister?

Mr FERGUSON - A fantastic relationship that has yielded incredibly positive outcomes for our state. I really value my personal relationship with the president, Dr Day. I equally valued my relationship with his predecessor, Dr Greenaway. Unfortunately, it is the case in life that despite a very positive, professional working relationship, it is just as life is that you tend only to hear about the disagreements or the areas where there are outstanding issues and challenges.

You have asked me to describe the relationship. That is how I do so. Without that relationship, we would not have got one health system, we would not have got to the white paper and breaking down some of the regional, very difficult issues around safety and service design. I always say thank you to the AMA, and not just the AMA, but many other health organisations as well. I am disappointed at times that there can be a focus on the areas where there is disagreement or where there is some work that is ongoing or a challenge that is unresolved. That is my attitude and I think that has yielded up some stunning outcomes for our state.

Mr FINCH - Minister, I was a bit surprised to hear a presentation today which was not very glowing in respect of the THS being top-heavy and multilayered; the operation being ineffectual; it being a seriously flawed design; current bureaucracy diverting resources away from health; botched health delivery; unwilling to address issues; a high-level government failure; and over-optimistic impressions. I was a little surprised to hear that negative assessment of what is happening in the system.

Ms FORREST - In the current structure, you're talking about.

CHAIR - Yes. The way it is currently operating.

Mr FERGUSON - Look, I am not going to be and I wouldn't like to come across as defensive about that, but they are pretty strong statements from the AMA, which has for many years provided strident criticism of health structures, CEOs and secretaries and local managers for many years. What I am focused on, however, is how you can constructively use each of our respective roles, respect each other, listen to each other and be prepared to roll up your sleeves and implement solutions. I am convinced there are solutions here because wherever there is a claim of top-heavy governance maybe there is another argument that we needed to look at how our state works as a population of just half a million people and how we can work together as a state while ensuring all our hospitals stay open and ensuring that if there is a willingness to adapt the way that services are delivered how we can do them better.

I hear the criticism of the AMA being directed at the THS governance. I always listen and I think that good people should be willing to work together for solutions, because the public deserve from us a belief in the future and an ability to work together, and that is what I commit to do.

Mr FINCH - The other comment was that reform and restructure is needed. From what you are saying you are open to those suggestions of communication with the AMA.

Mr FERGUSON - Always, and not just with the AMA. I wouldn't like to make too fine a point about this, but wherever good people can make healthy, constructive suggestions about how

we can do it better, this Government has always shown a willingness to do that. In the north-west where, as a new government there would have been every good reason politically to just leave it alone and not make any changes, we went through a very respectful process with the support of every mainstream health organisation, some of whom said, 'I don't reckon you'll get this over the line', and the opposition said there is a lot of pain in this with a grin on their faces.

The issue here is that as a government we have to be willing to challenge the status quo. We have done that many times and as I have indicated we have a willingness to listen to health stakeholders and empower and strengthen local governance, and I hope the record demonstrates that. I ask the committee perhaps to receive a further follow-up from me, which I am happy to write and submit in the usual way, so I can show you the way in which we have been able to implement that in the south and how we will progressively do so in the north in a way that is fit for purpose locally. In Launceston and Hobart there are significant differences as to how it could be implemented so that it fits the local purpose.

CHAIR - There are many angles we could go down here, minister, but one thing of concern is the feeling of the doctors in the system. I provided you with a copy of this survey so you had something to refer to, because the responses they received back, and this is the Medical Staff Association through Dr Frank Nicklason, who you would be well aware of. If you turn to the second page of that, these are some of the individual responses to question 1, which says, 'Which statement best describes your experience working at the RHH?'.

It is only the RHH, I appreciate that, but if you glance down through some of these, take the third one for instance:

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

There is obviously a heck of a lot concern within the clinicians in the system here.

If I go to another on that page - and this is just for the *Hansard* record really - you can comment back. It says:

> I really enjoy the opportunity to do the work I am doing. I am amazed at how receptive to feedback clinicians and non-clinicians mostly are. I frequently find frustration in finding ways to get approval to progress innovation because of lack of clarity about who has the jurisdiction to approve and champion change. Finances are one reason for lack of progress, but this is by far not the main reason. The main reason is an inconsistent, floating platform of leaders who have delegation to approve changes.

This whole survey has quite a lot of comment from individuals in the system. It is a concern and I would like to hear how you intend to address some of what you have just listened to. It needs to be addressed because clearly the system simply will not work without people being able to work in an environment of collaboration and wanting the same outcomes.

Mr FERGUSON - I am a minister who listens. We never stop listening. I note that the MSA will periodically do these kinds of surveys. I want to make an overriding comment that I respectfully receive and listen to this kind of feedback that is provided from time to time.

I have a couple of observations. The first is that without criticising the survey in any way, it is a small number of responses from our medical workforce. These are the ones who have chosen to respond, of which I note that 28 of the 64 have expressed dissatisfaction, 25 have expressed a form of satisfaction and 11 are neutral. What this tells me is that there is very mixed feedback.

The quotes you have selectively read to me I accept on face value as people who want to see us do better. When I say 'us', I do not mean government, I mean all of us. I mean government, our clinicians, our managers and our stakeholder groups. I will always listen to this kind of feedback - positive, negative and neutral - because it all helps us to drive towards improvements in morale, service provision and culture in our hospitals and in the community.

Ms FORREST - I would like to ask about who you take advice from.

Mr FERGUSON - I take advice from you and every other member of the Legislative Council. I take advice from my staff and the secretary in the department. I take advice from the THS governing council and its executive team on a weekly and indeed often daily basis. I take advice from our frontline staff who are always willing to engage with me on my regular visits to the various hospitals, wards and health centres. I also take advice from members of the public who many times say to me that they are extremely satisfied with the health service they experienced, but often they do not get the airplay. I also take advice from members of the public who feel let down or that the health service disappointed them. That is one of the richest and most diverse ranges of advice I receive.

I must say, it is the kind of range of advice that keeps you awake at night. It is a very difficult job, internalising and resolving many of the conflicting messages that we get. In the end the Government is responsible for the experience a person has and I often ask myself and my team how we can do it better and then demand from our senior executives better responses to some of those areas, particularly where there is a recurring pattern of disappointment.

Ms FORREST - Can I just narrow it down?

Mr FERGUSON - If I can finish. I want to point out that the biggest piece of advice I received in Health was when I was in opposition, just over three and half years ago, when people would tell me how sick and tired they were of being on the waiting list. It was the biggest issue in Health. Whatever anyone else may say, as a member of parliament I wonder if you would share my perspective that people were constantly feeling let down. They felt that they would probably never get their surgery or have to wait for months or years beyond the recommended time, in pain, disability or with blindness, away from being able to live their lives. That's been something that has driven us. It is an example of how we've been able to turn around that element of the health service.

Ms FORREST - I'm sure you and your staff have read all the transcripts and the submissions that have been published. What we have heard in this committee are consistent, repeated claims and concerns raised about the governance structure of the THS. I was a strong supporter of the one THS. As you know, I still am but I think that there are problems which need to be addressed.

We see decisions being made like the acute mental health observation unit at the Royal now not being open as that but used as something else. That's fine; I'm sure the space will be useful for other aspects.

CHAIR - Congratulations for taking the decision to revisit it.

Ms FORREST - Regardless, in my community and when I talk to health professionals and from representative bodies - like the AMA, ANMF, College of GPs, College of Surgeons, College of Anaesthetists, other people working in the system, the whole lot - I hear that there is an unhelpful culture. Within the high levels, there is dysfunction and a toxic environment. It is a threatening environment to work in, to report central events and adverse patient outcomes. We see bullying and harassment going on of people who do put their hands up. Who do you take advice from when you are looking at these structural problems at the top that don't seem to be getting any better?

Mr FERGUSON - I've answered your question about who I take advice from in a very broad way. If the question is: who do you take advice from in relation to governance and systemic issues, the answer is that they are plainly government decisions of which I am one member of the Cabinet. We make decisions as a team in the interests of our state of Tasmania. That is exactly how we arrived at this point. With all the adjectives and nouns that get repeated, like the ones that you've just said, I think it's worthwhile that provided they are being put forward by people who want to constructively contribute to something better -

Ms FORREST - They are.

Mr FERGUSON - Sometimes the choice of that language will only damage confidence in the health service for members of the community. I don't want to see that happen. When that occurs, as you would know as a nurse, people become frightened of using the health service. For that reason I have to be the voice of moderation in the way that we communicate, while accepting that we can always do better.

I point out, and I may as well just name it, what is happening here is that there are attempts being made to raise the issue of governance by the THS executive. Plainly that's a big concern. It's a concern for me and the people I work with. It's a concern for the governing council and the executive as a whole. We want to continually not just do the stuff of working together, listening and being willing to even adapt the way we work with each other, but we have to go the extra step of demonstrating that. I think we've done that.

We'll always try harder to improve. What matters to me most of all is that we continually improve what we inherited. Give me a chance to say that I inherited a complete basket case. We haven't completely fixed it, but we've made some great progress. The progress we have made has almost always, if not exclusively been, when we've worked constructively together. When I mean 'we' I mean the Government, the Opposition, members of the upper House and our health groups. We have had some great results, but we don't sit glibly on that and pretend that everything is all right. I'm a believer that we can always improve.

Ms FORREST - Is this the sort of area that the Deloitte review is looking at? We continue to hear the work that Deloitte has been doing has been going on for some time. As you know, we asked you for a copy of the report. You say there is no report. But surely you must have some feedback, otherwise why are we hearing so much about it?

Mr FERGUSON - I do have feedback. I hope you will trustfully believe me when I have told you honestly that there is not a report. I don't know how the mythology got around to the point that people choose not to accept it, but that doesn't change the reality. Thank you for asking the question. As you correctly pointed out, it relates specifically to the new bed implementation team. That was announced back in June. It's a whole-of-government effort, because nobody can remember a time where a government funded more than 120 additional beds in our hospital system. People can remember closure of beds by Labor and the Greens, closures of wards, but people can't remember this many beds being opened. It is a big effort and to support that the new bed implementation team is a work together by THS, the department as well as the Department of Premier and Cabinet.

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

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

I do not have a firm publication date at this time. A summary is currently be prepared, but I expect it to be released in the near future. I will have more to say at that time. This is an exercise by me, not just a commitment to opening those beds, but to working with our staff and constructively engaging. Hopefully others will do the same. To support the public interest in this, I will have more to say and will want to release that summary.

Ms FORREST - Did Deloitte look at some of the governance arrangements? Is that included in this? Concerns have been raised, whether you like them or not, repeatedly, about the micromanaging by the CEO of the THS, the dysfunction that has been talked about in terms of the overarching organisation, and the lack of local decision-making capacity. Did Deloitte look at that?

Mr FERGUSON - What I can say? Can I just preface my answer by addressing the preface of your question? It is not a case of like it or not; I receive feedback and take it in good faith. I will always want to use it to continually improve how we run our health system. If I can answer this broadly without straying from my definite knowledge, I believe that Deloitte did look through those interviews and surveys on how we are operating as a health system. It is a pretty broad descriptor. That involves how culture and morale are involved, as well as leadership.

Ms FORREST - Did you give them terms of reference to consider?

Mr FERGUSON - I don't have the terms of reference in front of me, but I would have access to them as a Cabinet member. The exercise by executive government was the new bed implementation team. It has been gathering resources to support that work.

Ms FORREST - Can you provide the terms of reference to the committee?

Mr FERGUSON - I can't commit to doing that. What I will commit to doing is providing further information, because I'm aware of the public interest.

Ms FORREST - Why can't you provide the terms of reference?

Mr FERGUSON - I'm not committing to doing that. I am simply saying that I will provide what I can, bearing in mind that there are longstanding conventions in place regarding Cabinet documents.

Ms FORREST - Surely the terms of reference, which are directing the inquiry, would not be confidential. That should be information that could be readily released so we can understand what is being looked at.

Mr FERGUSON - Ms Forrest, I am not avoiding the question. What I am saying is that I will provide what I can. I will need to take advice.

Ms FORREST - We will have the argument next week when we get a letter saying, 'No, I can't provide it.'

Mr FERGUSON - I will provide what I can. I will always take advice on that.

Ms FORREST - Minister, we wrote to you asking you about this. Surely, you could have got your advice before you came before the committee.

Mr FERGUSON - Ms Forrest, I have done that. In fact, I've been reading from the advice. I don't hold this against anybody but the premise of the letter was that there is a Deloitte report. I am just respectfully putting forward the response that there is not a report, but I have received a briefing as part of a Cabinet subcommittee. I understand the public interest in this. I hope that the motivation is always how we can improve. That is certainly mine.

Ms FORREST - We did write to you again when you said there was no report, saying we wanted to question you about these matters that were being considered by Deloitte. The terms of reference are fundamental to that.

Mr FERGUSON - I am very happy to provide what I can, but I am not in a position to release Cabinet documents.

Ms FORREST - I am not asking you to release Cabinet documents. I am asking you to release the terms of reference which guide the inquiry. The report and the briefing, I can almost accept are Cabinet documents. Mind you, we had that argument -

Mr FERGUSON - It may be possible for me to provide exactly what you are asking, but I would need to take advice.

Ms FORREST - I will be seeking that.

Mr FINCH - The RACGP, the Royal Australian College of GPs, spoke to us earlier, minister, and talked about a $50 000 allocation to GPs to stop re-admission to hospitals, with a suggestion that that re-admission would save the Government, was it $10.5 million?

CHAIR - It was $10 million, I think. It was 200 organisations and $50 000 an organisation. I think that was it.

Mr FINCH - Are you aware of that idea, that thought bubble, that the -

Ms FORREST - It is more than a thought bubble. This proposal -

Mr FINCH - This proposal by them.

Mr FERGUSON - Thanks, Mr Finch. I certainly stand to be corrected, but I learned about the proposal when you did through the reporting in the newspapers today. It may be possible that I have been written to by the Royal College on that subject, but I am not aware of it. I am certainly not intimate with the proposal or how it is appropriate that state government funding should be directed to a Commonwealth-funded service, which is our GP provision through the Medicare system.

I would need to see some strong analysis about how and why a state government would be the appropriate funding body for general practice. I hasten to add though that we do strongly support the Tasmanian Government's responsibilities around hospital and community care properly in its portfolio, working hand in glove with the primary care sector, which is predominantly the responsibility of the Commonwealth. We owe that to each other, both levels of government. I would be always happy to look at proposals from the Royal College of GPs.

Mr FINCH - You will be able to read their presentation on the Hansard later, but they did say they have been highlighting this since 2014 to the THS and the minister.

Mr FERGUSON - I would be very happy to look at that. I hope you will allow me to repeat what I said before, I stand to be corrected, but I am not aware of a proposal for a $50 000 payment to GPs as you have described, but of course I will check my records. I have a good relationship with the Royal College. I am frequently engaged. There are many issues and subjects that we discuss. They are pretty constructive meetings and exchanges of letters. I am certainly aware of the Royal College, over many years, seeking additional funding for general practices to continue to sustainably operate.

Mr FINCH - There was talk about poor discharge processes from the hospital system.

Ms FORREST - Discharge summaries.

Mr FINCH - Sorry?

Ms FORREST - Summaries and feedback. Not the process so much as the summary.

Mr FINCH - They were the words that they used. It was poor discharge from the hospitals anyway and the information that comes back to the GPs. Are you aware of that situation?

Mr FERGUSON - Yes, I am. It has been a longstanding and significant problem, which has demonstrated - of all the positives that we have from our national Federation of Australia, the Commonwealth and the states and territories - one of the weaknesses has been the very split that we have been talking about in the previous question and answer. This is where GPs are predominantly self-employed or corporately employed in the private sector, but heavily dependent on the Medicare rebate system. Then the separation that naturally exists with a state government-operated public hospital system.

One of the areas where that shows up is exactly what you and Ms Forrest have identified around discharge summaries. In my strong belief, GPs need to get those discharge summaries as soon as practicably can be done.

CHAIR - It is a week, I think. They have to wait a week to get relevant information sometimes.

Mr FERGUSON - I would not be surprised if in some cases it might be that or longer, and at times GPs have expressed to me the immense frustration that they have had on this. What the Government has done in response is first of all, as I say, listen closely to that feedback and respond. It is my understanding - and perhaps I can add this to a later letter to the committee - that discharge summaries are going electronic, but there is still the need for the notes to be prepared.

There is a commitment by THS to provide them in an increasingly timely fashion because we know how important they are. It is technically known as a discharge, but really what doctors tell me is that they want it to increasingly be seen as a transfer of care from one doctor or care provider to another. That transfer of care should be facilitated with that information, absolutely, and as soon as possible.

CHAIR - Minister, when I read your submission there seems to me to be an attitude of covering your bases with respect to what the previous government may have done and how you are addressing some of those issues and concerns that were basically caused by previous governments. Now I have said this to you before, not in a forum like this, but we are not here as an inquiry that is looking at any political outcomes here. We are looking at the particular issues that face our state with respect to acute health services delivery. It is not our desire to get into a political fistfight from one party to another. We really want to try to find the real information and detail as to why we are where we are at and to be able to provide some recommendations.

To that end, do you see that there could be a real benefit in a long-term strategic framework that says this is where we want to be in 10, 15 or 20 years time maybe - whatever works out to be the most efficient way of dealing with strategic frameworks - that is signed off by all parties as multi-partisan? That everybody - every party - understands that we need to be at this point in this period of time. That the arguments are about the minutiae as to how we are travelling down that particular path, not what is outside that framework.

Do you see that as a way forward and do you think that you would have the desire to put something like that in place? So that it takes the political heat out of forward planning, so that governments of any colour are not being seen to be the original thinkers, but the facilitators, and helping to garner cross-party support to get to that point?

Do you see a benefit in doing that?

Mr FERGUSON - I see a huge benefit in taking the politics out of health but as you would be well aware, Chair, health has become exceedingly political at elections. You only need to look back about a year and a half and you will see one of the most ferocious and dishonest campaigns that was waged on health. What that points to is that no matter what the truth or otherwise is on an issue, if it relates to health then it is going to be political.

What the Government has focused on is exactly what you have proposed - a long-term different direction. It would be unfair to forget to acknowledge the efforts of previous health ministers to do the same thing. David Llewellyn and Lara Giddings both attempted a similar approach. The times were different, I acknowledge that, but I will hasten to add that one of the reasons I believe that we have succeeded in getting to a document that you were able to hold up earlier - the white paper - which is a completely new direction for the way that health service planning should occur in this state. We got there because rather than just imposing a solution or making government the original author of this, I have always adopted the attitude and approach that we have to go to the community with humility and not with all of the answers but we ought to be strong enough as leaders to be able to say these are the problems we face.

The Government published the green paper, which was one of the most warts-and-all documents you will ever see a government admit to, and we said where we knew we were not doing well enough in both safety and timeliness of care. I believe each of you were at those different meetings when we then took that to the community and asked for it to be a shared problem. I do not claim any authorship of that document because I often say we wrote it. We as a state, government and non-government, public servants, clinicians, members of the community and almost every single mayor in Tasmania, have been part of that document and while not everybody is absolutely delighted with every part of it, people understand the good sense and objectivity to it.

I welcome that to this day the Tasmanian Government, the Tasmanian Opposition and the Tasmanian Greens, the three major political forces in this state, have all agreed on one health system. They have all agreed on the white paper and they have all agreed on Rethink Mental Health which is our longer-term, 10-year time frame with short, medium and longer-term actions. I can only say I am very grateful that this is the case, while however health nonetheless gets argued about around the margins and around how things are implemented, which is fair enough.

CHAIR - Don't you think we should be focusing more on the actual outcomes and the paths to get there than the political fighting that occurs? It is wasted, isn't it?

Mr FERGUSON - I'm not sure I agree with you that that is exactly where we are at. Health as a policy area is highly politically charged. You are seeing a lot of campaigning around health, even though there is not necessarily a policy agenda to support a better way forward. My approach is that we now have long-term planning in our health system. As with everything in life, it is not perfect, but if we are willing to listen to each other and genuinely are willing to work together toward implementing it, we now have the road map.

I don't believe there is a single stakeholder who would want to deviate from the One Health system, the white paper and Rethink Mental Health. That is a watershed moment in our state. The real issues for us I suppose now in these times are how we are implementing it, how effectively we are working together, and whether our decision-making process best supports all

the relevant players being able to have a voice and express a view about how we get there. I say fair enough, let's have those conversations.

CHAIR - We have major organisations and stakeholders in the system like the AMA and others saying that it is not working. There needs to be some -

Ms FORREST - Not wholesale change.

CHAIR - They're not saying wholesale change. You are quite right; they are not saying that. They are just saying that the way it is operating is simply not effective and indeed is getting in the way of getting good outcomes for patients. It is also reducing morale at the coalface and all these other sorts of things. Wouldn't it be good to have it acknowledged across the board that this is an issue and we need to collectively find a solution for this through the organisations that are experiencing these sorts of things and then fixing it and not being afraid of the political argy-bargy? If you've got them all on board and there is a tick saying that is where we want to be it is going to be the populace that holds them to account at the end of the day, isn't it?

Mr FERGUSON - I don't disagree at all with where you're coming from and in my evidence, when you look at it later, you will see that many times I am humble and realistic about where we are at. I never miss an opportunity, however, to remind myself and the people I am speaking with about the significant achievements we have made. Unfortunately, some of the testimony you are getting does not acknowledge those gains. That is a shame because if we don't acknowledge them we lose the ability to say to people we have the capability to make further improvements. That is the only reason I make those points: the Government has a record investment in our health system. Never before have we seen a $7 billion budget, and we need to ensure that we use it to get the most effective results.

We have never seen - at least in my experience as an adult - a government opening so many beds in such a short time frame. These are growing pains but we have to work through them and I would say quite humbly that it's far better to be opening those beds than what the more recent experience has been of closures.

Ms FORREST - Can I just -

Mr FERGUSON - I want to acknowledge your earlier interjection on your chairman, which is that it's not the whole system. There are elements we can improve -

Ms FORREST - It's just that there are things I'd like to get to and we're going to run out of time. You say that things are going okay but there is still work to be done and all that sort of thing. We've heard from a number of witnesses in different parts of the state and they are saying things are okay in some parts - it's not all bad - but we're trying to focus on the things they have identified as not working. So you don't need to take it too personally; it's about the areas that need to be focused on, otherwise we can just have a nice little talkfest and all go home smiling.

I want to talk about the 4K upgrade at the LGH. There are seven beds that won't be serviced in the current planning but if it is done now before the build actually starts it will be cheaper. The clear indication is that those beds will be needed, so why aren't we looking at that? We also looked at the K block at the RHH with the acute inpatient mental health facility. There has been a reduction in beds over years. I understand the focus on community mental health because that is where the majority of mental health patients are better cared for, however there is a terrible lack

of community-based mental health, particularly in the north-west. My GPs up there cannot get support for their mental health patients at all. They're dealing with really complicated mental health patients because there is no-one to send them to, and the facility in the north-west is not ideal. The North-West Maternity Services know how much I love this.

I congratulate you sincerely on getting rid of the Evergreen contract for septic services - well done, but it should have been done years ago. That gives us seven years now to fix it in such a way that we don't continue to see lack of continuity of care for women there who are pregnant and lack of job satisfaction for midwives who are having their scope of practice stymied because they're working in both antenatal and labour and birth care. It is absolutely not ideal for the midwives or the women. There are a lot of areas still not okay and I'd like to know where you think these things can be addressed. The key question from North-West Maternity Services is will you look at, within seven years, having a plan to put all public birthing back into the public system?

Mr FERGUSON - I appreciate the opening comments and the public deserves to see the full picture of Health in all of its negatives and positives. People often say to me, 'Will you please thank the staff for what they did for me, it was fantastic care and service'. We understand the bed pressures and that we have seen increasing demand, the like of which haven't been experienced before, particularly around the worst flu season in many years, if not ever, in our Tasmanian hospitals. We have more work to do, and that is acknowledged. Thank you for the compliments but now I will just take the points.

First of all, on 4K, this has been a very exciting project for our Government. We announced the money for the capital rebuild of the children's ward in the recent Budget in May. That has been a necessary investment for a very dated facility. What we have done there is very specifically designed it to be future-proofed. The whole concept here of making sure - and this did actually take additional funding from Government after that budget, by the way. I am not sure if that emerged today.

Ms FORREST - They did mention that.

Mr FERGUSON - We have provided additional resources so that we can be more confident than ever that not only is it meeting the needs that we have currently and the demands of patient numbers, but also the longer term. To that end, I believe I am giving you the correct advice. I will need to confirm this, but I seem to recall that we have designed the tender which is currently in the market to, in fact, potentially take account of the additional beds as well.

Ms FORREST - Fitting them out?

Mr FERGUSON - Yes. I would like to confirm that after this. That is my recollection because we wanted to know what the pricing would come in at from contractors. Naturally, budgets are important, but what we have actually designed is the superstructure in the shell so that it is future proofed.

Ms FORREST - The (?) able to give us those figures by either doing it now or doing it later today. I am sure they would be there.

Mr FERGUSON - I am not an expert in that particularly, but from a matter of Government policy, we are very proud of our decision to invest in children in northern Tasmania, in particular,

the long overdue mental health inpatient beds for adolescents. I note that at a previous hearing this was emphasised by some witnesses. I have to say as a matter of Government policy, we are building that infrastructure, we are building those services for children and adolescents both in the south and the north.

Ms FORREST - I have served on three different committees looking at this over the years in my 12 years, and I hear it every time.

Mr FERGUSON - Unlike every other committee that you have been part of, we are actually building them. We are actually building them and it is happening and they are funded.

CHAIR - And staffing them?

Mr FERGUSON - If that is a separate question, I will address that as well. We are building the infrastructure. In both cases they are due for completion in 2019. For operationalising those, they will be matters that will be addressed in upcoming budgets for sure. You cannot operationalise them without the buildings. That is what we are building.

For J Block, I acknowledge your points, Ms Forrest, about the number of beds that are being provided. I thank you for your very constructive comment about the need to provide the continuum of care in the community as well. The Government has recognised the increase in demand for mental health inpatient beds. We have been called on to re-institute the 10 beds that have progressively been reduced over, not just this Government, but the previous one. Those people calling for us to re-institute those beds, failed to mention that the building has been demolished. It has gone. It has now made way for a building that is currently under construction, K Block. We have significant challenges around this. While it was my hope that we could have actually provided additional mental health inpatient beds at the Royal in a very space-constrained environment, that has not been universally supported and the decision has been reached that those beds would in fact be used instead for surgical and medical patients. That is an acknowledged challenge.

Where we go from here is that we look to the newly-established Royal Hobart Hospital executive to work to find solutions so that we can provide better care for mental health. I want us to do better for mental health. I really feel convicted that with all the difficulties and the challenges on site that we have at the Royal, particularly through the redevelopment of the site, I want to do better. I want us to do better. I feel disappointed in part that we were not able to get that over the line. In the absence of that, we need to look for other solutions. I plead the case as I have many times before, we have to work together on this.

CHAIR - Even the design of the new mental health space is in question, isn't it?

Mr FERGUSON - I hope not. People have their different points of view, but we are now building that infrastructure. If a project has been rescued, it is now in the air. The concrete has been poured -

Ms FORREST - It is only 32 beds.

Mr FERGUSON - It is maximum - I believe it is - I am going to just check this. We variously have provision for an extra space. I will clarify.

CHAIR - It is still 10 short.

Mr FERGUSON - However, we acknowledge that there has been a shift in care out of hospitals into the community. That has been not led by Government budget cuts, neither this one nor the previous. It has been a shift in belief that more care can be provided in the community. It is a great shame that my political opponents would really dare to describe it as a budget cut and try to scare people, which it was not. It was actually a shift in care. The models that were designed with the current J Block, which is a temporary solution, and the future K Block, which is being built for 2019, were based on occupancy and the best advice at the time. I have to take that in good faith.

Ms FORREST - But the community mental health is not there, minister.

Mr FERGUSON - On that, you made a particular point, Ms Forrest, about community mental health - the lack thereof in the north-west - and I will be very pleased to look at that. At Budget Estimates in June where I discussed this matter with your committee at that time, I can recall us in some detail discussing the 100 community care packages that we were funding in that budget which were statewide for children and adults. I will be very pleased either to correspond with your committee or you personally on that if I can do better.

Ms FORREST - GPs are telling me up there, minister, that they are challenged almost daily to find community-based mental health care for adolescents with mental issues as well as adults. They are not there.

Mr FERGUSON - Good. I will be pleased to further interrogate that and the last-

CHAIR - With respect to that, also mother and baby units that do not exist in the north -

Ms FORREST - And hardly exist in the south.

CHAIR - And hardly exist in the south. Something has to be done about those as well because of the number of presentations they get. We heard today that the number of presentations that they do get is not an indicator of the demand out there because they are simply not going to the hospital knowing that they cannot get assistance. Is there any joy in that space?

Mr FERGUSON - I can say in broad terms that the Government is wholeheartedly committed to improving mental health, not just the provision of care but also prevention and early intervention. That is where our policies on this reflect a belief in that, and if we can improve we have always shown that we want to.

The last part of the question was around birthing, which is perhaps the biggest decision that the Government has made in terms of service provision by locality in the implementation of the white paper. My opening comments on this is to say a big thank you to yourself and many other members of the community who have been a part of this journey. It has been very challenging, particularly for people who felt connected to the old model, which did raise some safety, sustainability and massive workforce problems. We have now reached a new model. The best way I can answer this is to repeat what I have said before. I believe in continuous improvement. Even though we have now reached a new direction for the provision of maternal in-patient obstetric and gynaecological services in the north-west, we can always improve. It is only one year old and we are currently going through an evaluation of the new model. Any lessons that can

be learned from that I would want to see implemented so that we can improve the care of maternal and gynaecological services to women, mothers and babies.

Ms FORREST - In terms of getting public maternity services into the public sector?

Mr FERGUSON - Well, I cannot make that commitment. We do have a contract. The Government has very successfully negotiated what was a forever contract down to a shorter timeframe and that has been a much more robust and appropriate contract for the Government to be entering into. I would not want to prejudice what happens beyond that timeframe today, but I will say that we can always do better.

I pick up on your phrase in your question, it is about continuity of care to the greatest possible degree. To me it is not about private versus public, it is about the experience of a mum and I want to make sure that her experience, from antenatal care to the day of birthing to postnatal care - which is provided in the public and private systems - is robust, safe and a happy experience.

Ms FORREST - It is about maintaining competencies for the midwife. They are not able to work across the whole scope.

CHAIR - Yes, that is what I was saying.

Ms FORREST - That is why, I think, to have a continuity of care across public patients in public facility then you get it. At the moment it is very fragmented.

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

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

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

Ms FORREST - Who is doing it?

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

Ms FORREST - Will this be publicly targeted?

Mr FERGUSON - It will be publicly shared with the unions and the community. Forgive me for repeating this point: we are about patient safety and patient quality - the safety of the experience and the quality of the service. While the service has been in place now for just over one year, we always believe that we can continuously improve any lessons from the evaluation we would want to see implemented in the most feasible way.

CHAIR - I interrupted earlier about the 4K build and the extra beds, and I talked about staffing of those beds. I do not know that you addressed that particular issue. When these extra beds are in place at the LGH, are they going to be provided with extra staffing to cope with beds? That is the point.

Mr FERGUSON - The answer that I provided earlier was around the capital. Can I just confirm that?

CHAIR - Yes.

Mr FERGUSON - The earlier question was around the build. To answer the question about operationalising that, they would be future budget decisions to resource any additional demand that needed to be met. That does include the adolescent mental health inpatient beds, which I have already previously committed will be supported. That will be a matter that goes through the budget process, but the Government is not building assets that we do not intend to use.

CHAIR - But intending to use them and being able to resource them effectively you can appreciate -

Mr FERGUSON - We are not going to build those facilities which are due for completion in 2019 without operationalising those.

CHAIR - I take you to some of the questions we asked in our correspondence to you last week. There were a number of areas that we wanted some information on: the cost of nursing overtime by hospital and by specialty; the number and cost of locums broken down by hospital and by specialty; the rate of turnover of specialists and non-specialist medical staff by hospital and specialty; and the number and nature of critical incident reports in four major hospitals and the processes utilised when assessing. Do you have any joy for us there today?

Mr FERGUSON - I do. I have come prepared.

CHAIR - I am glad.

Mr FERGUSON - I will take your lead on how we would like to do this. I can provide details on the cost of nursing overtime by hospital and specialty, I believe. I can provide information on the locums broken down by hospital and specialty. I can provide detail on the turnover of staff. What I cannot provide you today, but I commit to providing to you, is further detail on the critical incident reports. I believe that I was asked that question quite recently so I am seeking that advice and I need that to be provided to me duly quality assured. I can provide this to you either as a tabled document or I can take you through it.

Ms FORREST - You can table it then because there is going to be some question once we have had a chance to have a look at it.

Mr FERGUSON - This is my only copy. I will ask you what you would like to - I am in your hands.

CHAIR - If it is tabled we can copy it and that would provide us with an opportunity to ask some questions from it.

Mr FERGUSON - I am fair game now. Before we move on, I want to be very transparent with you about the latter matter. I do not have the detailed information with me but I have asked the secretary to provide it to me. I will provide it to you by letter in relation to critical incident reports in the four major hospitals and the processes used with assessing them.

CHAIR - Do you have a timeline that you are likely to be able to provide that?

Mr FERGUSON - I suggest seven days.

CHAIR - Okay, thank you.

Ms FORREST - You are not able to speak to the process you used to dealing with them now; you do not know what the process is for when critical incident reports are lodged?

Mr FERGUSON - I am the minister and I do not pretend to have all the operational detail that I would want to have in front of me to speak to something like that. It is a parliamentary inquiry, it is a committee hearing, I want to make sure that I get it absolutely right. I am very aware that there is a new process that was implemented in the early time of our Government and certainly from a Government policy point of view I am perfectly competent of speaking to that.

We focus on quality. We support the medical profession's ideal of having an open system that allows reports of poor occasions of services to be reported to be peer reviewed and full responses to be made. That is about as far as I feel government policy should extend without having the advice in front of me as to the detail of the process.

Ms FORREST - One of the things that has been raised around this is that, and having worked in the health sector as you know, it is a really pertinent point that often sentinel events, particularly when there is a morbidity or mortality that is quite clearly related to an incident of care, then the risk is it becomes a witch hunt of who to blame. You really need a culture of -

Mr FERGUSON - That would never happen in health, would it?

Ms FORREST - What is really important here is that there is an open process where it is non-punitive, where it encourages people to come forward. The only way you are going to prevent subsequent adverse outcomes is stopping at the first one, or at the sentinel event. It puts the flag up. Do you believe there is a non-punitive approach that enables people to come forward, to raise matters of concern when there are adverse patient outcomes?

Mr FERGUSON - Yes, I do. That is necessary. Further to that, there are some sentinel events that are now nationally reported, expected that they are reported, and that is now a condition of activity-based funding. These are absolutely contemporary forms of reporting in a modern health system and we certainly have that in place. I am aware that we have a more or less new system that's been in place for approximately three years now. It is absolutely encouraged that if a member of staff sees something they think ought to be used as a lesson, or a way of improving the way that care is provided, then they are encouraged to follow that process and get it responded to.

Not that you have asked me about it, but I would like to let you know that the governing council, which meets regularly, every meeting they actually have a case study. Even the governing council is aware of events that have occurred with often adverse outcomes and what the service did wrong, or how it let somebody down, or how staff didn't exactly get it right, and what the policy or other changes need to be to see it not happen again. It is a very high level concern, because that is how we continuously improve.

Mr FINCH - We heard some evidence today about training. The focus was particularly on interns and our future doctors and how important the pathways are for training. In fact, Tasmania, in that respect, is not keeping up with our counterparts on the mainland. Are you aware of that or you feel might need to be examined to make sure that we are able to compete when we are trying to attract our best and brightest to either stay in Tasmania or come to Tasmania?

Mr FERGUSON - There might be some specific references that I could follow up. However, pathways are vitally important, especially for a small jurisdiction. We have significant adequacy with our training institutions, particularly the university around pathways for both medical and nursing. It is quite weak in the area of allied health. Where the specialist colleges come into play, obviously that's an important part of the pathway of developing the next generation of specialists. By and large, the general practice and medical interns and nursing staff, we are really well provided for with our university. If there are areas of particular concern I am happy to seek that advice.

CHAIR - Minister, we had a submission from Dr Bryan Walpole. He was basically saying to us here in Tasmania:

> You have eight institutions: the Royal Hobart Hospital, the 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: the Hobart Clinical School, Launceston and on the north-west coast. There are nursing, pharmacy and now para-meds, which is quite a big faculty. None of them is integrated into clinical care, so there is no synergy whereby the researchers can do some clinical work, clinicians who do some research and all of them teach the students and are continual. In Tasmania it does not happen.

He points to the McEwan Review in 2016, Alastair McEwan, one of the senior executives in the National Health and Medical Research Council, was asked to look into the administrative arrangements of the quality in Australian hospitals. His recommendation is to establish six or seven academic medical centres around the country. We are talking about a new learning institution. He terms it a statewide academic medical centre. He says, there could be a joint appointments board so you get an opportunity for the whole system to be more cohesive and less opportunity for gaps.

I note in the white paper, and I cannot give you the page because it does not have page numbers on it - and I do not know why that is, but it is the one that is one the web and you might wish to have someone address that. It comes in under 'supporting the reforms' in that white paper. It is about the fifth page in and it says on that white paper:

> Embedding a culture of research and innovation is key to achieving a high performing health organisation. With the move to a single THS there is an unprecedented opportunity to maximise relationships with the university and other educational institutions, research bodies and the primary healthcare sector to enhance these functions collectively.

He puts up this idea of an academic medical centre for the whole state. Do you have any comment on that? Perhaps the University of Tasmania medical centre with three campuses. Do you have a comment on whether that is a way forward for the state?

Mr FERGUSON - This would be an unqualified and untested comment. I have not had any other organisations or stakeholders raise it with me. Dr Walpole is a much respected retired physician. I read the submission and found it of great interest. Without in any way committing to his suggestion, it provides good food for thought.

CHAIR - He is basically saying, at the moment it is all driven by budget rather than quality – 'waiting times in the Emergency Department and waiting lists and throughput in the operating theatres, basically outputs rather than concentrating on good outcomes, the quality side'. They are some of the points being made in his submission 2.

Mr FERGUSON - Sometimes outputs are exactly what you want to have performance measures to see how you are tracking because every performance measure is amalgam of large number of patients having an experience. In all honesty, I found it interesting. I would not commit at all to the recommendations, but it is good food for thought.

Where I do not draw any qualification is the importance of collaboration between our health service providers and our educational and research institutions. I put forward the view that there is a mature relationship between THS, a number of the private hospitals, the University of Tasmania, its faculty, the Menzies Institute and the Clifford Craig Medical Research Trust. That is to be applauded. I am well aware of specific work between the dean of the Faculty of Health, Professor Denise Fassett and the THS to examine how we can more closely establish joint appointments in a collaborative way so we can get the very best of both institutions embedded into the practice of clinicians.

CHAIR - Wouldn't it be a carrot at the end of the day for clinicians to engage with the system? If you are finding it difficult to fill a position in the north-west because they may not want to live there or for whatever reason -

Ms FORREST - I can't understand why not.

CHAIR - No, I cannot understand, it is paradise, we all understand that.

Mr FERGUSON - The tide has turned on that, but we might come back to that.

CHAIR - Wouldn't this be a way, if you are offering the opportunity for them to be engaged in the clinical side and also in the teaching side and possibly even research, that can end up being a bit of carrot to being involved in some of those more out of the way areas, I will not say isolated.

Mr FERGUSON - Without trying to flatter the Chair, that is an inspired comment. I think it is right and it is correct that some of those approaches can help overcome some of what we have experienced at different times that are obstacles to recruitment. It is a good way to think about it and that is why I am pleased that the university's faculty of health and the THS do increasingly look for joint appointments that are planned rather than after the fact, 'Can we have a look at doing this?'.

Ms FORREST - It is not really happening at the moment though.

Mr FERGUSON - I would say it is but perhaps it would always be something that can be improved. I am aware of specific efforts by the university and THS, going back at least a year, seeking to align those processes so that it is by design and to help attract the right staff.

CHAIR - It is not my idea. I am simply quoting from a submission. Wouldn't this be an opportunity where you could put it for the other parties to say this is a model that really shows promise, do you agree with this and therefore we go forward - I am not asking you to commit today - but you go forward and you look at the opportunities to be able to implement something like this, which could be a real advantage and be off the political boxing ring. If you can get some cross-party support for something like this that would be a good way to go.

Mr FERGUSON - I am very happy to continue to look at the principles behind Dr Walpole's suggestions, but there would be a lot of others who would also have perspectives on this and I would love to hear those as well.

CHAIR - No doubt and as you should. Simply because it comes up as a submission does not mean that it is right. I wanted to put it to you to see what your thoughts were on that.

Ms FORREST - Going to this information that has been provided, we know that locum costs in the north-west particularly have always been higher than anywhere else. But the Mersey and the North West Regional have $14.47 million in locum costs, whereas the LGH is just under $7 million, and the Royal Hobart Hospital is just over $1 million. It is a huge difference. There is evidence to suggest that locums on the north-west are being used more than they should when there are some specialists positions that are not being renewed on contract, and there are locums on arranged locum deals, whereas we have staff who want to stay there permanently who are not being offered long term contracts. There may be all sorts of reasons why that it. Maybe that person is not suitable, there are problems with their practice, I do not know, but it seems to be happening a lot. Surely we do not get all bad people up there. I know we don't.

Mr FERGUSON - Quite the opposite. Can I indicate if we are discussing locums now and this information that I have provided, the first thing I want to say is that we had this discussion at Estimates and when we did have that conversation I provided all of this information but only up to 31 March. This is now a reconciled full year and the figures are effectively what were predicted at that time but it is now useful to have a full picture.

I make a number of observations. First, as a proportion of our total workforce this is not a large percentage of our cost burden for medical staff. What we require here from policy is to use locums when required and to minimise their use where it can be avoided. Locums are useful and helpful to cover, for example, somebody's leave in an area where we do not want to reduce the service to the consumer of health services. But, as you would be well aware, there have been some areas where it has been very stubborn and very difficult to recruit permanent staff. The north-west has been particularly difficult. While I do not have the information in front of me, at our last Estimates hearing I provided you with quite a range of specific positions that have now seen the locum being replaced by a permanently employed committed staff specialist. One of the best examples of that has been with obstetrics and gynaecology.

There is progress being made. I point to the LGH. At the LGH where you have some locum costs around acute medical, I suppose that in part that reflects staff not just where it has been difficult to recruit but where the Government has instructed THS to put in place locum support for endocrinology and neurology in an area which has been classically, stubbornly difficult to recruit.

While the Government is willing and happy to provide the funds for the employment of locums, because we don't want to reduce the service to the community, we continue the effort to employ permanents. I hope to have good news on that in both neurology and endocrinology in the near future.

Ms FORREST - In terms of visiting - I don't know whether you were here when I was talking about the challenge for the GPs up in the north and north-west, the north-west particularly, in accessing respiratory physicians, neurologists, rheumatologists, endocrinologists, pain specialists, dermatologists and just about everything you can imagine, and they are just not able to do that. I know during the period where we didn't have a permanent obstetrician and gynaecologist, there was an obstetrician driving up - was flying at one stage and once the regular service was taken off the route, having to drive, which then takes basically eight hours out of your day where you can't be consulting. Would you consider providing for air transport for specialists to visit from the south of the state? Obviously if they've come from Melbourne they do not have any choice, which makes it a bit easier - the *Spirit* is a bit slow. This was taken away. I know that chartering a small plane for one person is probably not cost effective, but a number of specialists do come from the south to the north and the north-west to visit, so wouldn't that be a more effective use of their time and also in terms of their safety and welfare, the specialists themselves?

Mr FERGUSON - It's possible that I know the case that you are discussing, even though you haven't named, quite appropriately, the particular, but you are using it as an instance to make a general point. My working knowledge on this is that there is quite legitimately a need to not just provide a service to a community that doesn't have access to that particular specialist, but also to do so in a way that is appropriate for the taxpayer without getting into inordinate cost. That is plainly a balancing task that has to be met by responsible managers. In principle I can only applaud those medical staff and some nursing staff who see it as their role to provide a service not just in the area in which they live, but also further afield. Hats off to them. I know a number of them by name and they provide a vital service, particularly in the north, but more importantly in the north-west, which has been classically under served by access to specialists. That is to be applauded. I would always like to encourage that to continue.

Ms FORREST - Putting two or three specialists on the one plane, if you take eight hours of driving for each of those with their salaries, plus the car oncost, the downtime, it's not that much.

Mr FERGUSON - It may be a very good idea if you were to do that. For example, if it was just for one day perhaps you might say it is not good value even at that, but maybe one night overnight or a two-day session maybe something like that could be looked at. I don't want to sound like I'm committing to your suggestion, but I think it's a great, constructive idea for how we can get specialists supporting patients in different parts of the state, even though they might live in Hobart.

Ms FORREST - Currently the waiting times are extraordinary. For north-west people to see a respiratory physician is 14 months.

Mr FERGUSON - That's a long time.

Ms FORREST - Just for the first consult and a lot of these specialists don't do public practice as such, so $500 for an initial consult and Medicare only picks up about $90 of that.

Mr FERGUSON - I applaud the suggestion. I am also aware of one particular medical practitioner who wanted tens of thousands of dollars for a small number of sessions over the course of the year. So there is always a value judgment that does need to be reached. If there are innovative solutions like that, that can allow qualified staff to not waste too much time on the road, while providing a service to a regional area, the Government would be very happy to look at that.

Ms FORREST - The other matter I wanted to raise, and I raised it in parliament recently, was about how we are doing a very poor job in stroke care in the north-west.

Mr FERGUSON - I read your speech.

Ms FORREST - Will you look at that Victorian model?

Mr FERGUSON - Yes, I already am looking at that. I appreciated your contribution on that. I am considering and looking at proposals around improved access to stroke care.

Ms FORREST - I am pleased to hear that because patients up there are doing very badly.

CHAIR - They can't get transferred to anywhere - if there is a wait - for a stroke, is it four hours?

Mr FERGUSON - There is an importance of getting treated within the hour. I am not a qualified clinician but that is what I understand - time is everything.

Ms FORREST - Depending on the nature of the cause of it.

Mr FERGUSON - I suppose we should take the opportunity to remind the public that in the case of stroke, watch out for the face, arm, speech and focus on time, but ring 000 and allow the ambulance service to help you navigate that situation rather than take matters into your own hands.

Ms FORREST - If you can have the clot-busting therapies at Burnie hospital, then people can go home next day. Think about the cost savings there, minister. Thank you for looking at that.

Mr FERGUSON - I would like to assure you I would not just be looking at that cost. I would be looking at the potential opportunity of providing a person with a much better rehabilitation and return to a normal healthy life.

Ms FORREST - Then we can afford to pay for other things.

Mr FINCH - I would like to focus on the overtime for nursing. Page 1 of the material you have given to us. It reminds me of our circumstance at Budget Estimates when we are dealing with the Prison Service, and the increased overtime that grew like topsy when we started with about $2 million and ended up heading towards $5 million in overtime even though we highlighted it and sought assurances that it would be investigated.

I see here that you have given information that you are going to address these challenges and will focus on various aspects. But $8.1 million comes as a bit of a shock to me. I wonder how you get a sense of a figure like that that is in overtime. Much of it is in respect of double shifts and areas where it impacts on people's lifestyles, their health and, dare I say, an adjustment to expecting overtime and looking to factor that into their lifestyles.

It concerns me. I would sooner see that sort of money invested in recruitment and development of more staff so that we do not have a blowout of overtime to the amount of $8.1 million.

Mr FERGUSON - Thank you for the question, Mr Finch. I entirely agree with you on the value of minimising exposure on overtime and double shift. It is helpful to have the figures. I point to the Government's new policy, which has been in policy for about a year and it could be coming on to a second year now, on placing additional expectation on management to reduce overtime and double shift by placing a cap wherever possible to not exceed a cap of four hours of overtime, to put downward pressure on the number of double shifts performed. It is far safer if you can manage within a four-hour overtime than a double shift, which is 16 hours. That has been success, but success has been limited, especially during the flu season where we had unprecedented demand. It is easy to predict a flu season but nobody can predict the kind of flu season that we had last season which had a massive impact right around the country.

We really appreciate when staff voluntarily oblige their colleagues by agreeing to do the extra time on shift. I don't like to see nurses, or anybody, doing excessive overtime or double shifts, but we have to thank them when they do because they usually do it out of a willingness to be part of the team.

I also make the point that in key areas we continue to recruit additional staff. There are still recruitment opportunities for available nursing staff, in particular. In some of those areas, such as mental health and ICU, it is very difficult to recruit them because there is not the local supply, but we continue those efforts. Where we have to, we are even recruiting interstate and internationally.

While the costs are faithfully represented, this is what the overtime cost has been. Through an academic exercise, were you to fully eliminate all overtime and double shifts you would not have avoided all that cost because you would have been paying people ordinary time. It has been represented here and I have been pleased to see the policy in general terms, working. The best solution to reducing overtime and double shifts is by having some of those areas of workforce shortage being addressed through our recruitment efforts.

CHAIR - A question with regard to accreditation. There have been various concerns expressed and in one instance accreditation lost at the Royal Hobart Hospital in the psychiatry and also anaesthetics in the north-west, which I believe, by the skin of its teeth, has been averted. Can you provide us with some information with regard to exactly what has happened there and how we have managed to keep that accreditation? What do we have to do, as a state, to maintain that accreditation? I am sure you would have been made aware of it.

Mr FERGUSON - Sure. I can speak in as much detail as I am able and happy to engage in further questions. I will provide you with an overview.

Accreditation issues in this case are training accreditation issues. I am aware of a range of areas across the health service that have not attracted the publicity this one did, where accreditation was under review and the THS, properly, after an inspection about areas that needed to be improved, they have been improved and accreditation has been extended.

In the case of anaesthetics on the north-west coast, there has been some concern expressed about that. I am not in any way downplaying this. In addressing it, I can assure you that in my regular weekly meetings with my head of agencies, everybody is on notice to do everything they can and should to ensure training accreditation is maintained, regardless of whether it is under the public glare. Training accreditation is not a proxy for hospital accreditation. In the politics of what we are all involved in, occasionally those waters do get muddied. I highly value training accreditation. I see it as a key enabler of ongoing recruitment for key medical specialties and anaesthetics is a key part of that.

I am very pleased the engagement between THS and the College of Anaesthetists has been positive. The recent news that it has been renewed has been provided. As with every accreditation, even the ones that are renewed, it will require ongoing engagement to ensure issues, as they do inevitably emerge, can be constructively worked through between both sides.

CHAIR - Apparently here in Launceston at the LGH in January, they have had its training status for doctors downgraded. Do you have any update on that?

Mr FERGUSON - I did provide an update very publicly approximately four or so months ago where the College of Physicians has a clear understanding with the Launceston General Hospital about a pathway to have that restored to a level 3.

My advice is very clearly that the decision that was reached to accredit it to a level 2, as opposed to level 3, did not relate to any budget cuts or staff reductions. There was a recognition that in some areas - and I use a senior clinician's own words here - of service, in particular those ones we are finding hard to recruit to, neurology and endocrinology being two, are too thin to have warranted a renewal of the level 3, even though there had been no reduction.

What that has shown is colleges are tightening up on their own compliance arrangements to ensure the quality of their training product is maintained. I respect that and while it is very difficult for a minister to work with his or her health organisation to ensure that those accreditations are retained, it is pretty hard when there is a recruitment challenge.

On neurology, for example, I was a federal member in 2007 when Stan Shaker died, the late Stan Shaker. Upon his sad passing, we lost our only neurologist and there we were again with no neurology services.

It has been at least a 10-year journey of improving that. What the Government's approach is, it is again a demonstration that we get it, we understand it, we want to improve, rather than just replace Dr Koshy when he resigned, we want to employ two. And not just replace, but to make that capability more reliable and give us a better opportunity to get a genuine level 3 training accreditation as soon as possible.

I can assure you, and I might provide you with it later, the further detail on that because there is a clear understanding between that College of Physicians and the THS, that we are on a pathway to see that restored. That is going to take a lot of continued engagement.

Ms FORREST - What were the key issues with the north-west region with the anaesthetics, and what is required to be put in place to maintain it? The accreditation, that is, the training.

Mr FERGUSON - If you would allow me to provide that to you, I will provide you what I can. There is some individual areas of workforce and there is some individual areas of management that have been the subject of those negotiations as to how we can retain accreditation. To put it in broad form, and you will not be surprised to hear me say this, Ms Forrest, from the college's point of view, what they have said to the North West Regional Hospital is that it is about the quality of the training experience for their registrars. That is in the very broad form. Any further detail I can provide you that does not compromise any individuals on the ground, I will provide to the committee.

CHAIR - Thanks for that. In terms of staffing and bed numbers in various locations - and I suppose in particular, in my case I am looking at the Royal Hobart Hospital - how do you plan for capacity to be able to cope with things like national programs, such as colonoscopies? That can have a real impact on services. Do you have conversations with Canberra if there is a national scheme like colonoscopies coming into play that they provide certain funding to be able to enable extra staffing to cope with the outcomes of that?

Mr FERGUSON - Yes, we certainly do. I personally do. I have raised this, and so have my colleagues, state and territory health ministers, at regular meetings of the COAG Health Council. This is one of a number of areas where it is a clear demonstration of increasing demand. In this case, it is not because people are getting diseases of the bowel more frequently than before. There may be somebody who can point to that evidence. I am not aware of it. What is happening is that there has been an increase in the screening program which is turning up more positives for a fecal blood test that would potentially indicate the need for a scope.

CHAIR - That grows demand, doesn't it?

Mr FERGUSON - There you are. There is your increase in demand. From a Tasmanian Government perspective, we have been able to provide significant additional Tasmanian taxpayer funding into endoscopy. We have done that. We were able to demonstrate having really put a big dent in the endoscopy waiting list.

CHAIR - Do you get reimbursed for that from the Commonwealth? If they are putting these programs in place, is the state being reimbursed for the costs associated with supporting those sorts of programs?

Mr FERGUSON - I will need to seek advice as to whether those specific initiatives do qualify for national activity-based funding, but we certainly do feel the increased demand. To meet that we have provided increased supply of the service. It is one of those areas where we see increased demand. The last thing I want to see is people being referred for an endoscopy procedure and having an uncertain wait period. My attitude on this, and it is shared by the CEO, is that we should be providing as much guidance to GPs as we possibly can as to the anticipated wait time. Then, even if it is a longer wait time than is recommended, and even though we want to shorten that, if it is longer the GP can manage the care of their patient or at least provide them with other options in the meantime. I was very interested earlier-

Ms FORREST - The other options being?

Mr FERGUSON - I was very interested earlier listening to evidence that you were receiving from the College of GPs where there was an interest - which I have not heard before and was very pleased about - in different workforces providing endoscopy care.

Ms FORREST - Nurses are doing it.

Mr FERGUSON - Thank you, Ms Forrest, nurses are doing it interstate but not in Tasmania.

Ms FORREST - Yes, I did not mean -

Mr FERGUSON - Yes, you are quite right and I am thankful that you mentioned it. Without putting too fine a point on it, you will perhaps understand that there is difference of professional opinion -

Ms FORREST - Turf wars.

Mr FERGUSON - on that point. You can call it a turf war. I would invite your subcommittee to have a good look at it.

Mr FINCH - We heard evidence today that the gastroenterology - those services - fits into what you were talking about -

Ms FORREST - Endoscopies.

Mr FINCH - there is a 700 day wait for that service. That is a long time.

Mr FERGUSON - I can provide some context around that. I do not have the data in front of me, but we have been able to put a significant dent into the endoscopy wait list. Even the least urgent category would indicate a 12-month wait time and, as we have seen in Tasmania for many years, that has been excessive. This is why we rely on qualified staff to be making judgments about which cases are the most urgent. They are doing that, but inevitably there are going to be some that are in the non-urgent category that might have been something more sinister. That is why we always - while we are reducing the wait list and dealing with the increase in demand - encourage people to take that up with their GP if the wait is becoming excessive.

I would like to add to an earlier answer: I am advised that endoscopy activity is funded through Commonwealth ABF.

CHAIR - Okay, thank you for that. Moving to your submission - and you are being very generous with our time and I appreciate that - but we do not have too many opportunities to gain this -

Mr FERGUSON - You had me for nine hours at Estimates.

CHAIR - This is a specific purpose.

Mr FERGUSON - You asked me real questions so it was worthwhile, compared to the House of Assembly.

CHAIR - We have a habit of asking real questions in the Legislative Council. Talking about the period of time in your submission, I think it is on page seven:

> We are seeing significant growth in the number of admissions to hospitals in recent years. A recent measure of access block remaining broadly stable while there was a low in 2009-10.

You used eight hours as the measure. It is four hours now though, isn't it, that is considered to be the period of time that we should be under the NEAT system?

Mr FERGUSON - That is a national target that is nationally consistent, but it is one of a number of performance measures.

CHAIR - What are we doing in that space to try to pull back that time that we are measuring? It makes a big difference in how we look on the charts, if I can put it that way. It will be interesting to hear your comment on that.

Mr FERGUSON - That is a very correct observation, but the data has been presented as it has been for a reason. We report our performance on this, including through the budget papers, and nationally reportable data sets. It is also on the health stats website. I do not walk away from the national emergency access target, which is a target for every state and territory, which no state and territory meets. However, we want to and that is why our Government has committed over the next period of government that we will set as a target to reach that target for 90 per cent of cases, which as you can see we are well off and have been for many years. No government has been able to meet it.

What the graph on chart 3 is intended to communicate, quite apart from your point, is that even though the number of admissions has escalated in our term of office - just at the Royal - from 18 000 to nearly 22 000 admissions. These are not people turning up at the ED, these are the number of people who got a bed. Our hospital was able to provide those extra numbers, 3000 additional patients there, a bed that they were entitled to be admitted to while also holding the proportion waiting more than eight hours about stable. That is the only point that I was seeking to communicate through the use of that chart.

How are we doing that? It is through a number of factors, but impressively the opening of the unit that was closed by the previous government, which we call the ambulance offload delay unit. That has provided additional care, less ramping, but also critically opening more beds at the Royal Hobart Hospital is how we are able to provide those improvements. In the end we want to be able to provide beds to patients and even if the numbers are going up the additional beds provide more capacity for hospital staff to manage patient flow.

The second factor is ensuring that the patients who are currently using acute care beds when they are and not before they are safe to go home, they are adequately discharged with support. That is the point being made there. I reiterate that our Government recognises this as an ongoing area of need. If we had not seen those increased presentations I'm sure you would have seen that solid line go well down. We would have seen a substantially lower number of people waiting longer than eight hours.

CHAIR - Of course the mentally ill are sitting in the emergency waiting area these days for quite often long periods of time. You understand that that is a very significant issue.

Mr FERGUSON - Yes, it is and I've acknowledged that myself. I talked about that in detail quite some time ago about what I hoped we might have been able to achieve. I don't want to labour the point, nor seek to make any gain out of that, but I would have liked to have been able to provide a path forward for extra mental health beds, but that wasn't universally supported. To that point I believe there are still solutions in this space, particularly around some of the new models that we're putting in place right now, including through my colleague, Jacquie Petrusma, the Minister for Human Services, an innovative project that has opened up spaces for people who are homeless and currently occupying a mental health inpatient bed, which is a more appropriate placement for them, freeing up beds for patients who would have otherwise been waiting in the ED.

CHAIR - Or can't be discharged because there is nowhere for them to go.

Mr FERGUSON - That is the point I'm making. I am agreeing with you. That is exactly why that is being put in place just in recent weeks.

Ms FORREST - We heard evidence today about young people being kept in the children's ward of the LGH because there was no crisis accommodation for them. That is the only reason they were there: they weren't sick, but that was the only safe place for them to be.

CHAIR - They said three; there were three.

Ms FORREST - Yes, there was nowhere else for them to go as there was no crisis accommodation, which is not really your problem it is Mrs Petrusma's problem in many respects.

Mr FERGUSON - It's our problem and it is also family challenges as well as service providers. I'm aware of some specifics that obviously I can't and won't discuss. I'm aware of some very, very complex family situations that have been and would be tough for any parent, and where the THS and frankly out of the care and compassion of our staff who do find ways to care for people, even though it is not classically their care responsibility. The LGH is a place of safety under the act and our staff, to their great credit, do what they need to do to take care of very difficult situations. I am filled with admiration for what they do. I am grateful to be their minister. They do a wonderful job and I've picked up on that evidence from this morning. You can be assured I will be raising that, as I always do, with my colleague and we will look for solutions so that we can do better. It is about the best place, the most appropriate place, for the client or patient that requires it.

Ms FORREST - When you consider the capacity of the paediatric ward is often pretty full then potentially there is bed blockage and getting young people into the paediatric ward if these other people are there because there is nowhere else to go.

Mr FERGUSON - As a dad I take this really seriously. I feel as a dad I know how I would feel and I can assure your committee every skerrick of politics aside we will look for solutions here. It will require some innovation and some willingness from non-government providers to see what we can do to be better prepared for future cases where it is a family with no other place to go and they end up taking their child to the ED and driving away.

CHAIR - We appreciated the honest information that came to us this morning. Given the time of day and I am sure we could go on for another hour probably but we are not going to do that. I am getting a 'no' beside me.

Minister, thank you very much for taking the time. I do not know whether there is anything else you wish to tell us before you depart today.

Mr FERGUSON - I would like to say that you have had previous Legislative Council inquiries into the health system where the minister has not fronted. I have willingly fronted.

CHAIR - We do appreciate that very much.

Mr FERGUSON - I do so in good faith because I know what you have said to me about what is behind this inquiry. Also I will anticipate your correspondence looking for some further information in those areas where I have committed to do that. If there are any areas where I have not committed to provide the information but it occurs to you to ask I will provide you whatever I can in good faith and that it is not subject to cabinet-in-confidence.

CHAIR - The set up of this committee was designed to be apolitical; no party members on this inquiry. We cannot help what people do with the information that comes our way that is published. That is for them to deal with.

Mr FERGUSON - The fact that this is three months before an election does not trouble me. I am here to be open and transparent and provide you with whatever information I can to support you in meeting your terms of reference.

CHAIR - We may have an interim report, as I previously indicated, that deals with some of the information that was received to date because that would be expected of us, but it is not to say that the final report will be before the election. It is something for us to have to deal with.

Ms FORREST - It depends when you prorogue parliament.

CHAIR - It depends on when you prorogue parliament, yes, I suppose it does. Rest assured we are here for the right purpose, not for the political purpose, and that is the important thing.

Thank you minister.

Mr FERGUSON - Thank you.

THE WITNESS WITHDREW.