PUBLIC

THE PARLIAMENTARY STANDING COMMITTEE OF PUBLIC ACCOUNTS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON FRIDAY, 24 SEPTEMBER 2021.

REVIEW OF AUDITOR-GENERAL'S REPORT NO.11 OF 2018-19 PERFORMANCE OF TASMANIA'S FOUR MAJOR HOSPITALS IN THE DELIVERY OF EMERGENCY DEPARTMENT SERVICES

Hon JEREMY ROCKLIFF, MP, MINISTER FOR HEALTH, WAS CALLED AND EXAMINED.

Ms KATHERINE MORGAN-WICKS, SECRETARY, **Mr TONY LAWLER**, **Mr JOE ACKER**, and **Ms MICHELLE SEARLE**, DEPARTMENT OF HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome Minister. One of the roles of the Public Accounts Committee is to undertake follow up report reviews of the Auditor-General's audits. We do that in collaboration with the Audit Office to which ones they follow up and which ones the Public Accounts Committee might. The purpose is to go through each report. The recommendations selected for this year are Ambulance and the Emergency Departments. We will go through each of the recommendations. You have provided a response to the questionnaire which we sent which was really helpful. It would be helpful to elaborate on some of those and get a report based on the progress in regard to the recommendations of the Auditor-General

This is a public hearing, it is being broadcast. It is being recorded on *Hansard.* Parliamentary privilege applies to you and members at the table while you are in front of this committee. I will ask you to introduce each of them and get them to take the statutory declaration.

Mr ROCKLIFF - Thank you, Chair, and thank you for the introduction. I am joined at the table today by Kathrine Morgan-Wicks, the secretary of the Department of Health and the State Health Commander. I am joined also by Tony Lawler, the Chief Medical Officer, deputy secretary clinical quality regulation and accreditation; Joe Acker to my left, chief executive of Ambulance Tasmania; and Michelle Searle, the acting deputy secretary policy purchasing performance and reform.

CHAIR - Thank you. Minister, we will start with the emergency department review. If you want to make some over-arching comments about both, you are welcome to do so.

Mr ROCKLIFF - I do have some over-arching comments, Chair, that will be relatively quick. Thank you for the opportunity to do so. As expressed more recently in our Budget Estimates process, increasing community demand for health services is, and continues to be, a key challenge for governments across Australia as it is for governments around the world.

While all state and territory governments have significantly increased service levels to meet the rate of increase in demand, perennial challenges of ensuring the patient's receive timely access to care remain. Each week we read in national newspapers and on websites the same problems in other jurisdictions that we face in our community, including long waits in

emergency departments, ambulance ramping and timely access to elective surgery and outpatient clinics.

These problems are the symptoms of the effect if increasing demand on our health systems. In addition, we are also currently managing the impact of the COVID-19 pandemic which is stretching the capability of our health system in a way that has not happened before. As you are aware, to improve the transparency and currency of health information key information updates are being released monthly. The health dashboard update, which will be released today, shows despite delivering more funding, more staffing and more health services than any previous government, demand is continuing to increase.

The latest data for August continues to show encouraging improvements to the elective surgery wait list, reducing from 12 273 in January to 10 850, a decrease of about 1400 people. However, emergency departments, one of the topics we are talking about today, in Tasmanian hospitals are experiencing increasing pressure due to continually rising numbers of people presenting for care, especially at the Royal Hobart Hospital. In August there were 6371 presentations to the Royal Hobart Hospital ED, the second highest number since the record high in March 2021 of 6783.

This continues to present challenges in treating patients within an appropriate time frame. Statewide, demand for ambulance services also remained high with attendance at 7506 incidents in August, including 3445 or 45 per cent emergency incidents. The challenges of reducing long waits in the ED and ambulance ramping are complex and the Government has invested in a range of patient-centred initiatives to address these by establishing a statewide access and flow program reducing the need for people to attend ED to receive health care through partnering with the primary care sector to increase hours of access and urgent care; strengthening collaboration with the private hospitals, secondary triage; increasing our bed capacity so that people can be admitted from the emergency department to hospital care sooner; and providing more support to enable people to be discharged to their homes sooner, through expanding services in the community. There is, however, still a way to go. We must always strive to do better because behind every number is a person requiring care.

I am of the view that significant investment in Health is only as good as the plan for that investment. The department's strategic priorities 2021-23 sets out the priorities, actions and enables us over the next two years to provide our strategic direction to ensure that Tasmanians receive the best possible health services. It is vital that we all work together to implement solutions to the challenges in Health to ensure Tasmanians get the right care at the right place at the right time.

I am pleased to provide the committee a copy of correspondence recently received from the Australasian College for Emergency Medicine that supports the department's strategic priorities and its dedication to improving access and patient flow.

CHAIR - Thank you. We will go to recommendation 1. I won't read it right through as it is quite long. You have provided some evidence to note the actions you have been taking. I am interested to know where you see your progress is on this recommendation. I know most of these things continue to be works in progress. Some are not easy to tick off and say they are fully completed or complied with. How are you measuring any evidence of impact of the adoption of the recommendation?

Mr ROCKLIFF - You have my response to recommendation 1. It is not worth repeating it.

CHAIR - No, don't repeat it. I am asking about how you are measuring impacts and outcomes from the changes you put in place.

Ms MORGAN-WICKS - With recommendation 1, we have a focus on whole-of-system health leadership. Since February 2020, and it took effect on 1 March, we instituted our new governance structure for the Department of Health, which tried to bridge the practical divide that had existed between the Department of Health and the Tasmanian Health Service.

To be fair to its authors, this report does go to governance, particularly at the back of the report - the concerns in previous years about attempts to hold systems to account, a performance framework and a department basically asking another service to continue to report to it. Since February 2020, we have done all that we can to operate as one department of Health. The timing of doing that has been very positive, particularly given the outbreak of COVID-19 and the efforts we all had to make to work together as one team to manage the pandemic.

Access and patient flow and the impact that has across our health system, as you'll note, is a key priority in the Department of Health's strategic priorities, and that is Department of Health including our THS, including our ambulances services. One of the very first priorities in that access and flow column is that we are making access and patient flow everyone's business across the Department of Health. That is our expectation.

CHAIR - I note in your response it said you were establishing an effective governance structure.

Minister, in many respects it was heartbreaking to read through the Auditor-General's report when you look at the governance and cultural challenges that have existed. It took me back to a time when it was pretty tough. You said, 'Strengthening the governance framework provides accountability, transparency, responsiveness to change. It also clarifies and confirms local decision-making authority and accountability.'. You go on to talk about the clarification of roles and responsibilities. Do you have an organisational flowchart that shows how this works? Are you able to provide that to the committee?

Ms MORGAN-WICKS - We have published several organisational flow charts showing the structure of the Department of Health both from a functional view and from an individual authority or accountability view. We could provide copies of those structures.

We have three chief Health executives who are responsible for our operating services in Tasmania. We have our chief executive of our Hospital South which is not just the RHH but all associated, so part of that broader RHH campus. We have our chief executive for our Hospitals North/North West. We also have our chief executive for our Community Mental Health and Wellbeing. They sit around a single executive. There is not another executive layer that we then point to and say, 'You are responsible for that and we require you to perform'. We are responsible for the performance.

CHAIR - Who holds those positions?

Ms MORGAN-WICKS - We have Susan Gannon who is the Chief Executive for Hospitals South, we have Eric Daniels who is Chief Executive for Hospitals North/North West and we have Dale Webster who is the Deputy Secretary, responsible for and the Chief Executive for the Community, Mental Health and Wellbeing portfolio, which includes ambulance.

CHAIR - Will the flow chart or some sort of documentation you'll provide outline the roles and responsibilities of all in it? That was one of the big challenges the Auditor-General identified and we know has been a problem, is the clear lines of reporting and responsibility and accountability. Does that document contain that or can you provide information regarding it? In many respects, this is what the recommendation is referring to.

Mr ROCKLIFF - Yes, I am sure we can provide that information.

Ms MORGAN-WICKS - As part of the health executive structure, we have clear responsibilities, by portfolio or division and also accountabilities at the health executive table.

In reading the Auditor-General's Report, which probably harks back to evidence that was collected many years ago now and in different organisational structures, it is probably a little bit of a world away from the way in which we are operating today. At that health executive table, we also have, for example, a deputy secretary who is responsible for infrastructure across the board in health in Tasmania. I have a chief information officer who is responsible for technology across the board, whereas previously in this report we probably had many positions that were responsible. At times people do an amazing job within their silo or pocket but what we need to see is the strategic decision-making right across the health system so that we can make decisions faster.

CHAIR - The reporting of all those positions will be evident in the information you provide? The lines of accountability and responsibility were referred to by the Auditor-General.

Mr ROCKLIFF - Yes, I understand.

CHAIR - Maybe we can discuss the work done around the cultural change that was needed. In the Auditor-General's Report there was significant commentary on that on pages 38 and 39. As the secretary said, a lot of this refers to historical reviews and reports. Can you tell us how cultural change is being monitored and what changes you have made, not only as a result of the Auditor-General's Report but from other areas as well?

Mr ROCKLIFF - Thank you. We are mindful of the report and its recommendations and its mention of culture. We may have covered this over the course of the last couple of weeks in our $15.7 million investment to support cultural improvement across our Tasmanian Health System, across all sites and all areas, which is particularly important. It is important for a variety of reasons.

First, everyone who works within our Tasmanian Health Service does a tremendous job under difficult circumstances. We want to ensure that every one of those individuals feels safe, that they are respected and that they are valued for the very good work that they do. What is important culturally within the organisation is that people can express an opinion and see

opportunities for growth within the Tasmanian Health Service with regard to their aspirations and opportunities for promotion.

Ms MORGAN-WICKS - Through the minister, cultural change is a long process. It is well underway across the Department of Health, the Tasmanian Health Service and the Ambulance Service. We are moving to a broad-scale cultural change piece that is patient-focused with respect for each other and our patients no matter how diverse as they present. That change is happening right across our health service. We will be probably announcing more to our staff in coming months as our new chief people officer is appointed and leads that cultural change program.

In the instance of access and flow, the key cultural piece is about every single staff member understanding that they are playing a part in a patient's journey. Often access and flow or ramping of ambulances, for example, will be seen as an emergency department problem or an ambulance problem. However, it is a whole-of-hospital and a whole-of-system problem. It extends into our integration with primary care and our integration with aged care. Our statewide access and patient flow program has it at its heart the support from our emergency care network and our college. At number one cultural understanding is critical.

CHAIR - Have you seen any tangible changes or measurable outcomes from the body of work that has been done to date. The divide between the emergency department and the wards when a patient needs admitting were described quite clearly in the Auditor-General's report. Have you seen changes in that?

Ms MORGAN-WICKS -The changes we are seeing are probably most evident in the roll-out of our integration operations centres in each of our hospitals. There was reference to that in the Auditor-General's report. That was probably the early days of the IOCs being contemplated. We are now seeing really strong participation in IOCs from across the hospitals. For example, at the Royal Hobart Hospital at 8.15 a.m. every morning there is a huddle on safety and the environment in the ED and the impact that that is having on admissions and discharges across the hospital. It's trying to encourage a one-team perspective on access and flow.

CHAIR - Can you just describe for the committee how the integrated operation centres work? There is one in each major hospital. How do they coordinate this patient flow improvement?

Ms MORGAN-WICKS - We have an integrated operation centre operating in each of our major hospitals and to a lesser extent we have information flow happening in district hospitals. We have a connection from our IOCs through to those district hospitals. Our integrated operations centre, for example, at the Royal is a very large area with walls filled with dashboards to monitor the information they need to make sure that beds and patients are flowing through our hospital system.

The Royal is right at the centre and will take not only its own patients but transfers for particular types of care throughout the state. We have a mixture of staff that are in the IOC. At the moment we have the departmental head of our emergency department sitting in our integrated operation centre. Dr Emma Huckerby has been assisting in our IOC to bring that strong emergency department perspective and to work with our general medicine teams who

will take the bulk of the patients out of an ED. It monitors our ICU beds and what impact surgery is having on those beds and tries to improve the flow.

An ambulance representative sits at times within the IOC to ensure that the right information is coming from the road in to the hospital. That is very important when there is major trauma, or road trauma. These IOCs are improving. The Royal's was opened over the past 12 months, so it's starting to gather pace. It needs the whole of the hospital hearing the information, responding to the IOC, and the IOC having the authority to admit and make decisions.

CHAIR - That has that authority?

Ms MORGAN-WICKS - The IOC makes decisions and is advocating bed movement through the hospital.

Mr WILLIE - How are those decisions communicated with the broader staff? Through COVID-19 and the lockdowns there were communication issues in the system. When the IOCs make a decision how is it communicated?

Ms MORGAN-WICKS - I might also ask our chief medical officer to comment. He has been pivotal in the interest in access and flow-on improvements that we are going to make. Communication is at the heart. That is something that every day we are trying to improve across the health system. The IOC has all the information at its fingertips and is able to make directions as a medical head, but also with a nursing director responsible to get out to the key leads in each of the hospital areas. That might be a nurse unit manager, for example, or a particular doctor to take on the care of a particular patient. They are the strongest advocacy points in a hospital to make sure that flow is occurring.

Something like, for example, direct admission rights is a project that we have in our statewide access and flow program. That is quite controversial, but we will be working through that over the next 12 months.

CHAIR - That is a work in progress?

Ms MORGAN-WICKS - Yes.

Ms WEBB - You mentioned that the IOC at the Royal has been in place for 12 months or so now. What is your data telling you about the difference it is making? What are you anticipating from here, granted that it takes a while to imbed and get things operational?

Ms MORGAN-WICKS - The Royal has had a virtual IOC for longer than 12 months, but as part of the K-Block re-development and the infrastructure works we created a new integrated operation space that is dedicated to flow. Regarding monitoring, every hour in every day determines what impact it is having on the flow of the hospital. This will be impacted by the significant increases in presentations that we are seeing in the ED.

As part of our statewide access and patient flow program, and all the projects that are in that program, and there are examples on our strategic priorities, that will benefit the integrated operations centre. They will be rolling out these projects, implementing them and educating our staff across the system about the improvements we are making.

Ms WEBB - My question was probably, how will you know how effective it has been in making improvements? Part of that is thinking about how you will know whether this is the right way to be doing this, or whether you need to do further adjustments, or take a different tack once you have assessed how effectively it's making improvements?

Ms MORGAN-WICKS - For each project we are rolling out under the statewide access and flow program we will be undertaking evaluation and publishing that evaluation to each of our teams and staff that have been involved in the projects. I have been upfront with our staff saying that for many years and for many reports and reviews, suggestions or recommendations have been made about particular projects that can be taken on to try to improve access and flow in our hospital system. These things include a med-tasker technology tool that was really called out for and which we have successfully implemented over the past 12 months across our hospitals.

We have had projects such as the IOCs, which we have now rolled out across our four majors. Each of these are not the ultimate answer to access and flow, but together we hope they will build that success. We would like to see an alleviation of our escalation levels across our hospitals. We also, in terms of the improvements we are making, have that against a very significant rise in ED presentations. We need to balance additional beds or resources in addition to these projects that we are rolling out.

CHAIR - The last point made in your response to Recommendation 1 was that there is development of a suite of consistent reporting measures, encompassing an integrated metric strategy covering experience, process, impact and balancing measures, that provide a snapshot of access and flow performance - and that is underway. How will these measures be reported? You are doing the evaluation, and I assume you will provide that to all the staff. Will that also be available to the public?

Mr ROCKLIFF - Thanks, Chair, for the question. I understand the importance of timely data for the public to absorb, and the sense of accountability and continuous improvement. An example of this is that we are, today, releasing the dashboard for the month of August. In October, we will be releasing the last quarter, in many respects.

We are trying to provide timely and up-to-date data for the public, to ensure we are all accountable to the decisions, changes and improvements we make and the investments required.

Ms Morgan-Wicks can talk more directly about the additional data, and about it being made public for public consumption, and how that would relate to the dashboard.

Ms MORGAN-WICKS - I also have Michelle Searle at the table, who is the head of our monitoring, reporting and analysis division. In addition to now making a monthly dashboard available, we have committed to the College for Emergency Medicine that we will adopt their KPIs and targets for our emergency department.

We are also working together with our emergency care network - which involves the heads of each of our emergency departments across Tasmania, together with other key staff across the hospitals - to make sure we are monitoring the ACEM targets. We are also working through this list of improvement projects under our statewide access and flow program, to try to lift our performance against those targets.

CHAIR - Does that include how we report against those?

Ms MORGAN-WICKS - Yes. Our performance in the emergency department, in terms of the wait time for patients to receive care, is on a publicly available monthly dashboard.

CHAIR - Will there be any new measures? Some of this work being done, which will flow through to waiting times, and times to admission or discharge - that is the measure we are talking about. I am trying to clarify that there are no additional measures that will be published as a result of the work being done.

Ms MORGAN-WICKS - We do look to try to increase the information we publish in relation to KPIs and targets. I don't want to say that we're not going to publish any more, because I know, for example, that we will be including the latest College for Emergency Medicine KPIs and targets in our service plan, which we then report against as well.

We have a suite of KPIs and targets that operate across the health system. Our health dashboard is probably the highest level that is now available for the public to view, every single month. We also report in the budget papers and against our service plan on the targets that are listed in those documents.

CHAIR - I haven't read the ACEM letter, but does it detail all the KPIs they recommended?

Mr LAWLER - The access targets that have been developed by the College for Emergency Medicine are publicly available, and they have been discussed and presented by the college to our emergency care network. They stream patients on the basis of their disposition - patients who are admitted to hospital or transferred, patients who are discharged into their own care, or patients who are admitted to a short-stay unit.

They have different time targets for each of those streams, and different thresholds and KPIs for those targets. For instance, 100 per cent of patients should have an emergency department length of stay of no greater than 12 hours if they are admitted, or 90 per cent should have an emergency department length of stay of no greater than 8 hours, which has traditionally been our target, and is consistent with the definition of access block.

There is a similar stream for discharge patients, and for those who are admitted to short-stay unit, such as an EMU, or an observation unit within the emergency department.

In discussions with both the college and the emergency care network, those hospital access targets have been adopted. That is clearly articulated within our strategic priorities. The letter from ACEM indicates the fact that they welcome our adoption, and they will be incorporated into our public reporting.

Mr ROCKLIFF - Chair, I have the Department of Health governance structure, and the THS executive in greater detail as well. They are provided to table.

CHAIR - Thanks very much. One other question. On page 28 of his report, the Auditor-General talked about the EMUs, particularly at the LGH, being used contrary to government policy, and that they were used as a way to shunt patients out of the emergency medicine department when they actually needed admission to the ward, rather than being a short-stay

patient who was expected to go home. Has government policy on that changed? If it has not, are the EMUs being used as intended and according to government policy now?

Mr LAWLER - Through you, minister. The intention of an emergency short-stay unit or an emergency medical unit is really for that one-third of patients for when we do not have a clear disposition decision on where they are going to be. It varies from service to service, and hospital to hospital, but the general intention is that 85 per cent or more of patients would spend less than 24 hours and would then go home.

If we knew everybody who was going to go home, and everybody who was going to be admitted, we would not need a trial area to provide that care, so there is an expectation that some of those admissions to short-stay will convert to admission.

In some settings, that is described as a failure of trial, but really, at the end of the day you have asked the question, 'Can the patient be cared for and then discharged within 24 hours?' and the answer has been, 'No', and so they have gone into care.

The intent is that it is an area for patients requiring short, sharp, less than 24- to 48-hour treatment. It should not be used as an inpatient ward. Obviously, there are times when decisions have been taken simply for the purposes of providing care to those who urgently need it, but some discussions have been made.

A lot of work is being undertaken to provide a better option and alternatives and avenues. The map that is outlined in the strategic priorities around maximising the bed footprint, and all the work that has been done through the access and flow program on better bed utilisation and decreasing length of stay, are all aimed at preserving the emergency short-stay unit - both at the Royal and Launceston General Hospital - to be utilised for those patients who either need short treatment, or are waiting for investigations to have a better idea of their disposition.

Ms MORGAN-WICKS - Through the minister, it is an interesting observation in the Auditor-General's report. I don't know that I agree with it. There is a key place for a properly functioning AMU or EMU, and we probably have different iterations of it across our hospitals - particularly if care can be provided outside the very busy cubicle spaces in emergency departments where, for example, someone might need intravenous fluids for a certain period in a quieter area, and be cared for there, and then return home with a particular care plan, rather than being admitted upstairs.

CHAIR - We will go to recommendation 2, about the department urgently reviewing the root causes of growth in ED adverse events. You have provided a fairly brief response, saying that the root cause analyses conducted on all Australian adverse events with a rating of SAC1. Can you give us a bit more information on what is happening there? Minister, do you believe you have fulfilled the intent of that second recommendation?

Mr ROCKLIFF - Thank you, I will throw to Tony shortly. We had some information in Budget Estimates about root cause analysis and the 218 events over the past five years where root cause analysis would generally be expected. Fifty of those were last year. There were 188 root cause analysis reports recorded in the safety reporting and learning in the past five financial years. In the same time frame there were 30 events where root cause analysis has not yet been received. It could be for a variety of reasons but the service is still within the 70 days they have to investigate the event and complete the report and the service complete a different

type of review, such as the cluster review and the lookback review. Would you like to expand on it?

CHAIR - You said all investigations are shared and entered into the safety event learning system. I am more interested in the outcomes of that. What changes have been made as a result? The intent is to learn from things that have occurred that perhaps you would prefer not to have.

Mr LAWLER - There was significant discussion when we collaborated with the Auditor-General's Report. We do have a fairly clear and robust safety event management policy that covers events that occur not only within our hospitals but across the publicly funded health systems.

There was a concern at the time that many of the events that had been entered, not only SAC 1s but predominately SAC 2s and SAC 4s, that related to ramping were in some instances listed as patient safety events, whereas they were potentially infrastructure resource-based events. We do go through that process of analysing the nature of events and whether they are tied specifically to patient events, which is an instance wherein a particular level of care or nature of an intervention has led to direct harm to a patient.

For clarity, what we undertake is a basic risk category assignment activity where the impact on the patient and the likelihood of that occurring results automatically in the generation of a severity assessment code or SAC rating. We have a policy expectation and a reporting expectation for all SAC 1 events that there will be a reportable event brief, a REB, which is a summary of the event provided to the department within 48 hours of its occurring. Then a root cause analysis which is mandated for all SAC 1s or sentinel events, which is a nationally determined list of so-called 'never events', has to be completed and provided back to the department within 70 days.

We have a process that is overseen by our Quality Patient Safety Service in terms of where the recommendations sit with that. It is a shared responsibility between the local organisation in terms of where the event has occurred, the root cause analysis. We talk a lot about closing the loop. Closing the loop isn't just checking whether the recommendations have been implemented. They are checking, as you allude, to ensure that the recommendations, having been implemented, prevent that kind of event occurring again.

We have strong collaboration and cooperation between the Health Services. This is reflective of the organisational and cultural changes that have occurred. We have a clinical executive that sits under and reports to Health executive. It has representation from all the publicly funded health services. There is the executive director of nursing, allied health and medical services from each of the hospitals, from auricle services, statewide mental health services, and also the director of improvement. That is in turn supported by a safety, quality and accreditation subcommittee that has oversight of our safety and quality systems on a standards-based approach. One of the things that we are working through is a more refined and sophisticated reporting suite such that we are able to report on the status of events, their investigation and how recommendations we receive from a number of different sources might be root cause analysis. It might be Auditor-General, it might coronial recommendations, the progress on those and how they are being implemented, which then gives us the ability to report not only to clinical executive but also the health executive in turn.

We have a sophisticated mechanism in place to ensure that we are getting to the bottom of the causes of these high severity incidents and monitoring the implementation of recommendations.

CHAIR - You may not have an answer to this, but I am interested in putting all that together. It is useful to collect the data from many sources to identify where the problems may have occurred and where the points of intervention might have prevented it. Have you seen changes in practice and process that you can clearly link back to that process? Is it too nebulous to do that?

Mr LAWLER - Probably one of the best examples of that is the fact that we have taken such elements as the Auditor-General's recommendation, the findings of previous reviews and used them to inform the development of our access and flow program.

Solutions such as: the use of Medtasker as a communication tool; the escalation of care; the development and current review of the integrated operation centres, including the inclusion of mental health and Ambulance Tasmania staff within those centres; the cultural work we are undertaking; and work that's being undertaken between the hospitals and Ambulance Tasmania through the emergency care network on inter-facility transfers and direct admission all go to the fact that we are incorporating these findings on an ongoing basis.

CHAIR - Thank you.

Dr BROAD - The recommendation asks for a review of root causes of the growth of adverse ED events. I didn't hear if you had an understanding of what the root causes of the growth in adverse ED events are. You have talked a lot about process, but do you have an understanding of what was driving the growth of adverse ED events as noted by the Auditor-General?

Mr LAWLER - We analysed the root causes of the growth in events by analysing the root causes of the events. Whenever we have a report that indicates a SAC 1, we undertake a formal root cause analysis, which is a very formalised process whereby we bring together key stakeholders and directors of improvement and also consumers and analyse the individual operational, environmental, human factors and so forth that lead to an event. We identify root causes, we identify recommendations that contributed to and recommendations that are identified but didn't contribute to. In identifying the growth in adverse events, we are undertaking that work by doing that on an event-by-event basis, identifying the issues and responding through system-based rather than individual-based processes.

Another example is, in the past, we saw medication errors that occurred through transcription of medications when patients came to the emergency department, or medications being added or being removed when they shouldn't have been. The implementation of our partner pharmacists' medication charting, which is a model that had been utilised elsewhere and we've using now, in which the reconciliation is undertaken by a pharmacist within the emergency department, the charting is undertaken, the junior doctor is sat down with and discussions around these issues that have occurred have virtually eliminated serious adverse events and, as elsewhere, have indicated length-of-stay improvements. It has been rolled out statewide with similarly positive responses.

Dr BROAD - If I ask a simpler question, what were the root causes?

CHAIR - If I could reframe slightly or add to your question, Dr Broad, did you identify any common factors that were happening that caused the increase in adverse events?

Mr LAWLER - We have identified a number of issues that were prominent features in adverse events. They included medication errors and an increase in ramping. We have obviously focused very many of our access-and-flow implementation issues on ramping as an end result of access block. We undertook an analysis. We understood from the report from the Auditor-General that highlighted the event type, which highlighted the growth. I think I mentioned this in Estimates last year and I re-emphasise it now that it is tempting, but not always supportable, to take growth in reported ED adverse events as necessarily a one-to-one correlation with the growth in adverse events.

One of the challenges is that adverse events are self-reported in that they rely upon a clinician entering them into the system. While we are comfortable that we have a positive reporting culture and part of that from anecdote and from talking to staff is because people see that there is a response to reporting. In some organisations the reporting rate is very low because people don't see a point. The converse of that is that as the reporting culture improves reported adverse events go up. That is sometimes taken as an indication that care is not safe, or the standard of care is deteriorating. I don't think that should be taken as a one-to-one correlation.

Ms MORGAN-WICKS - If I may add, medication or IV fluids errors was one of the significant adverse event categories identified in the Auditor-General's report and which pharmacy charting, the initiative under our statewide access and flow program, directly targets.

CHAIR - We might move to recommendation 3 regarding the cultural improvement we touched on earlier. You have listed a number of strategies or programs there. Which ones have been implemented? Is it all of them, or some are still a work in progress. There is the Pathway to Excellence cultural change program, the Speaking Up for Safety cultural change program and the Insync staff engagement survey.

Mr ROCKLIFF - The ones that we have listed there are either all being implemented, or in the process of being implemented.

Ms MORGAN-WICKS - Can I provide an update?

Mr ROCKLIFF - Yes.

Ms MORGAN-WICKS - Our Pathway to Excellence cultural change program is an internationally recognised framework. It is aimed at driving organisational cultural change, particularly in our nursing cohort. The pathway program requires us to provide evidence of the work that we undertake under six standards: shared decision-making; leadership; safety; quality; wellbeing and professional development. Achieving a statewide designation will require nine separate applications to be made to Pathway to Excellence. We commenced that in mid-2019 in the south and we are now commencing that in the north and north-west. It requires dedicated teams to be set up in each region to push and promote each element. We are surveying, we are educating and training and getting people participating in those improvement programs so that we can then satisfy an external accreditation.

CHAIR - Someone comes back in later, minister, and undertakes an evaluation of the success of the overall program?

Mr ROCKLIFF - My understanding, yes, it has been evaluated.

Ms MORGAN-WICKS - Yes, it is externally evaluated. We have to do the applications and provide significant amounts of evidence that we are achieving the change to that threshold requirement.

CHAIR - When do we expect that finalised report to be undertaken?

Ms MORGAN-WICKS - I don't have a date at the moment, but the program is under way. It will probably go for the next couple of years.

CHAIR - There may be lessons along the way?

Ms MORGAN-WICKS - We had a pilot program in the south. We are taking those lessons, particularly the resources required to support our staff through the program, into our north and north-west implementation.

In addition to Pathway to Excellence, we have Speaking Up for Safety cultural change program. More than 1500 staff, both clinical and non-clinical, have attended scheduled presentations as at 1 July. We have had a further 12 Speaking Up for Safety presenters receiving formal accreditation in March this year. That brings us to 22 accredited presenters that we can use across our 14 000 staff. That program is also being rolled out in the north and north-west.

CHAIR - You could argue the success of this one would be reporting away adverse events. This follows Professor Lawler's comment that people feel safe to call out things that they are concerned about that are safety issues. There probably needs to be commentary around that in terms of media attention to those sorts of things should that become an issue?

Mr ROCKLIFF - The context?

CHAIR - The staff feeling that it's still safe to speak up.

Mr ROCKLIFF - The staff should feel safe and be safe to speak up. That may be a flow-on effect of more reporting and hiding some challenges within the system.

Ms MORGAN-WICKS - It is critically important that every staff member feels that sense of safety to be able to speak up. It is often difficult in hospital systems which traditionally have been very hierarchical. Not just in hospital systems but the ambulance services and other healthcare settings. People may be nervous as an intern or as a first-year nurse, for example, to mention that they were concerned about a particular treatment incident. This is about trying to empower all our staff to work together but to be able to call each other out if they are concerned and to ask questions. It is not about blame. That is where it is difficult to handle some of these incidents. In doing a root cause analysis we are trying to recognise where a deficiency has occurred and to rectify it for the future.

Mr WILLIE - Has the delivery of these programs been impacted by things happening in the health system, for example, COVID-19 or Royal Hobart Hospital is at level 1, I think, where you need to call all staff in? It is obviously going to have an impact on trying to deliver these programs.

Mr ROCKLIFF - The pandemic has caused some concern, Mr Willie.

Ms MORGAN-WICKS - The pandemic has changed the way in which we, for example, train, educate and bring together gatherings of staff. We have had to alter some of our models of delivery, particularly as we pivot to a bit of online but also socially distance and get to enough staff members.

Through the north-west outbreak the recommendation was to improve our ability to communicate to our staff and to employ mechanisms other than email or printing things out and sticking them up on nurse unit manager doors or walls. We are trying to pull those into this cultural change program.

CHAIR - Do you want to speak briefly about the progress of the Insync survey? When are you likely to have any feedback from that survey that could give effect to the cultural change?

Mr ROCKLIFF - Sure. I am trying to find additional information that we may have provided previously. In addition to the nursing and midwifery engagement surveys, Hospitals South engaged Insync to conduct staff engagement surveys for medical in February and March last year, November last year, and allied and health and clinical support services in February and March last year. Following completion of each survey Insync presents directly to the Hospitals South executive team, providing an overview of results. The presentation is available from Hospitals South intranet pages accessible by all Hospitals South staff.

Access to unit results are provided to heads of department and discipline leads to ensure each area can share both positive and negative results with staff and participate in the development of individual action plans to address any identified issues in the north west and north. Hospitals were undertaking a nursing and midwifery survey and nurse leaders are currently working with their teams to discuss actions to address issues that have been identified. Opportunities are being explored to implement programs and initiatives aimed at fostering a positive work environment across the entire THS and Department of Health, including with investment.

Ms MORGAN-WICKS - For example, the Royal Hobart Hospital has done the Insync engagement survey twice. Each time we have action plans that are associated with the feedback that we receive. Our second Insync survey showed improvement.

CHAIR - I assume the same sort of questions are asked, so you can monitor improvement through that?

Ms MORGAN-WICKS - Yes.

CHAIR - Is this an annual process?

Ms MORGAN-WICKS - It is not like the State Service annual survey, for example. It is one we can choose the timing of, particularly when we are aware, for example, that we have actioned all the actions identified, and whether we do another reach-in to check on the engagement. It is not the same right across all of our health sectors. For example, our chief executive for Ambulance, Joe Acker, has been working with ambulance officers and has been conducting a resilience scan, should you wish to hear another example in addition to Insync.

CHAIR - Is Insync used across the ambulance service as well?

Mr ACKER - With the resilience scan, we have engaged third-party consultants, Frontline Mind, to survey our staff. It is a narrative-based approach, so we can understand exactly how our staff are feeling about the culture of the organisation, and work towards improving that. We intend to redo that in three months to see if we are moving in the right direction.

CHAIR - There is obviously a positive feedback loop, with the recommendations that are made through the survey back to staff, and then the next one will also show where the actions are being taken.

Ms MORGAN-WICKS - It is iterative.

CHAIR - We will move to Recommendation 4, Education of staff to produce access block. We touched on some of this under the first point. We talked about some of the other measures such as Medtasker and Partner Pharmacist. I don't know that we mentioned the Tasmanian emergency care network and the public-private hospitals partnership working group. These are all things that have been done to support this area.

Can you talk about the outcomes of some of that work, and the improvements you have noticed with areas we haven't talked about, such as the emergency care network or the partnership working group?

Ms MORGAN-WICKS - The Tasmanian emergency care network was re-established and is now up to its fourth meeting; I thought it was in the diary for next week. It is co-chaired by the head of the emergency medicine department at the LGH, Dr Lucy Reed, and also Dr Juan Carlos Ascencio-Lane, the current Tasmanian president of the Australian College of Emergency Medicine. He was also one of our specialists in the RHH emergency department.

That network is trying to bring together representatives from both EDs and, critically, other senior representatives across the hospital system - for example, our heads of general medicine and ICU representatives - as well as primary care, and our ComRRS initiative, making sure they are connected in trying to avoid ED presentations.

At the moment, probably the most critical outcome that has been delivered by the ECN is to achieve agreement on what the priorities are for the statewide access and flow program. That program pulled out every single review that has been conducted in any hospital in Tasmania in relation to access and flow, harking back to things like the Richardson Report. More recently, the Newnham and Hillis Report on the RHH has also pulled out all the past recommendations.

We have gone through each of them to work out what is still current, and to try to pull them into strategic themes, which we now see, and we have named as one of our strategic priorities for all staff.

The ECN has been fantastic trying to get everyone on board - some are more critical than others for some sectors of the hospital, and they'll have their favourites - together with a real push on recruitment, especially for nursing staff in emergency departments, which I know is one of their top priorities.

CHAIR - It seems like a no-brainer, in many respects, to pull together all the recommendations and take a coordinated approach.

Mr ROCKLIFF - It is, and as the secretary addressed earlier, we look at what is still relevant in those ideas. I remember being present when the Richardson Report was presented back in 2003 or 2004 at Devonport Town Hall. Some of those areas haven't been picked up, but some are still relevant. As Ms Morgan-Wicks said before, some might be small in nature, but when you add those areas up, the package of those smaller issues can make a big difference, we are anticipating.

Ms MORGAN-WICKS - The ECN is another way to hold the statewide access and patient flow program accountable. It has the key representatives across our hospital system - particularly the members of our emergency departments, who are at times very vocal in advocating for the best for their patients, to improve flow. Our ambulance service also attends the emergency care network meetings.

I have attended each meeting to make sure that, as secretary, I have a full understanding of the critical items on their list, to make sure these are in our strategic priorities. Mr Acker, as chief executive, and Mr Lawler, as our chief medical officer, also attend. They have very senior people trying to come together to help them identify solutions to access and flow in Tasmania.

CHAIR - And the public-private partnership working group?

Ms MORGAN-WICKS - Our private and public working group has come together on a very regular basis through COVID-19 to, for example, agree on supporting agreements during the COVID-19 pandemic for access to decant to beds in private hospitals, and the support to be provided to private hospitals with the cessation of elective surgery during COVID-19 for a period last year.

That group is trying to make sure we have a really positive and accessible relationship between the public and private system, noting that we work together every single day. We need to make sure we maximise and leverage our opportunities to purchase beds in the private system, for example, to help alleviate access and flow. That may be beds to support rehabilitation for surgical patients after surgery, to try to free up beds in our public system. It may be general medical beds.

COVID-19 is another example when we will need to tap into that capacity, should we experience another outbreak in Tasmania.

In terms of that private bed buy, a Tasmanian Government election commitment provided some $20 million for that public-private partnership, to look at instances where private hospitals can step up even further to assist us with beds, or other initiatives - whether it is a private representative in our integrated operation centres each day trying to see if they can pull private patients through to private hospitals to free up greater bed capacity in our public system.

CHAIR - You still have a number of private patients accessing the public system for care they could access in the private hospital system. Not everything can be, obviously, in Tasmania.

Ms MORGAN-WICKS - As is each individual's right to do so.

CHAIR - Yes. But it could help to move some of those people.

Ms MORGAN-WICKS - If we can offer that opportunity to patients who are presenting at public systems, should they wish to elect to use their private membership, I think that's positive and helps free up other beds.

CHAIR - We will move to Recommendations 5 and 6, which you dealt with together. I wasn't entirely sure about the clinical utilisation review framework project. Can you explain how that works, and how it integrates with the other systems you've been talking about, with regard to addressing these recommendations?

Mr ROCKLIFF - Thank you, Chair. In addition to what is there, can I ask Mr Lawler to provide some information?

CHAIR - This is about avoidable admissions and unqualified admissions particularly.

Mr LAWLER - It is, but it is also a little broader. It is also around understanding where in the system the latency is - that's the term we tend to use - where there is occupation of beds or utilisation of service that is not adding value for the patient or for the service. We are talking about times where there is a wait for a service that should otherwise be delivered earlier, so potentially allied health where discharge is not being effected in as timely a way in which we can so.

The Making Care Appropriate for Patients (MCAP) process is delivering a mechanism whereby we can provide real-time understanding of that. There have been some forays into this in the past. We look at tech-enabled solutions such as patient journey boards, for instance, where you can have a visual dashboard of the journey of an individual patient through their care. You can use that on a time-based triggered mechanism to understand where delays such as waiting for a discharge script, or waiting to be picked up, or waiting to access allied health services. This is a real-time mechanism that enables us to understand the utilisation of clinical services' gross deficiency.

The framework itself is working out how, once we have the data, we can most effectively utilise it. Obviously, that will feed into the broader program of work that sits under access and flows. How do we use Medtasker, which is a workflow communication management tool, to ensure that the relevant staff are able to be matched to the relevant tasks; how do we do that to ensure that we are targeting the deployment of resources, particularly allied health? It ties in

with some of the other recommendations if not for a 24/7, then a 7-day hospital model. It is around the operationalisation of the data that we gather through the MCAP project.

Ms MORGAN-WICKS - From a non-clinician perspective, probably the strongest information we are getting from use of the MCAP is a sense of the proportion of sub-acute patients who are in acute beds. It is significant to us to have a tool so every single day an overnight patient is receiving that evaluation and there is a comparison nearly to the average of a patient presenting with this type of condition - the time and duration of stay that is appropriate care for that patient type. We do know, for example, that we experience some severe bed block for patients who are waiting under NDIS in terms of packaging, and underage care waiting for appropriate decisions to be made. At the moment the public hospital bed is that last resort for those patients.

CHAIR - To date, are you seeing any reduction in those non-qualified and avoidable admissions? NDIS is still bedding down in many respects but are you seeing any reduction in numbers of those patients?

Ms MORGAN-WICKS - It is very early days with our MCAP tools. It has only recently been rolled out.

CHAIR - Really?

Ms MORGAN-WICKS - For example, we have an implementation currently that started in May 2021. I was looking for the statewide Mental Health Services or our district hospitals such as the Midland Multi-Purpose Health Centre, so as not to always start some of these initiatives straight into the Royal but try to look at other opportunities. We are looking at it now in our district hospitals in the north. Go Live in our North West Regional Hospital and Mersey Community Hospital will be first major rollout. I think once we start to get it into our bigger centres, we will be able to publish further results in relation to MCAP.

CHAIR - Recommendation 7: Change and manage capability in skills and project management. I think we have talked mostly about those aspects. How long has the Statewide Access and Patient Flow Program been in place?

Ms MORGAN-WICKS - The Statewide Access and Patient Flow Program commenced in late-2019. I am just trying to remember. I cannot remember the exact date. It worked throughout the pandemic 2020, but probably in a less visible way. It has really been re-energised in 2021. I note, however, that they did work very quietly behind the scenes, in terms of the Medtasker and pharmacy charting roll-out, all through 2020 and 2021.

They have quite a list of projects and we are now building up all the resources in that team to make sure that each of these can be delivered. That is probably the major issue that the Department of Health has traditionally faced. It is very clear what the recommendation is. It is making sure that we form programs of work and probably resource those programs of work to deliver the projects and not expect busy clinicians or non-clinicians in our hospital working environments to be able to do these projects as well as they can. So, we do it in conjunction with them. We design together with them in a co-design approach but we make sure they have some resources that are entirely dedicated to the rollout, including change management resources, which we haven't always been the best at investing in. There is now a square piece of our Statewide Access and Patient Flow Program.

CHAIR - So, you will see more date from that once they can really emerge from the COVID-19 blanket.

Mr WILLIE - Can you give a bit more information, minister, about the clinical networks.

Mr ROCKLIFF - Thank you, Mr Willie, Michelle?

Ms SEARLE - The clinical networks - we have recently just released our Clinical Senate Issues Paper, that is going through a range of options to look at how we engage and establish a clinical senate. As part of that discussion will be looking at how the framework sits with our clinical networks and how we can improve the collaboration across the senate, the networks and gain visibility across the works that they are doing at the moment and where their priorities sit.

Mr WILLIE - For someone who does not have a health background, in plain English, please? The clinical networks obviously help to inform change, but what are they made up of? Who is involved in them? Can you give us some real examples of where that has worked in action?

Ms SEARLE - For example, our surgical network has the heads of the surgery in it; a range of staff across the state. They are the ones who have worked really closely to develop the Elective Surgery Operational Plan.

Mr WILLIE - It says, 'consumers', here. How are they are involved?

Ms SEARLE - I am not exactly sure of the membership, sorry. I will have to come back to you on that.

Ms MORGAN-WICKS - We have various examples. We have clinical networks, for example. We have, as Michelle has mentioned, our statewide surgical network. We have our stroke network and our endoscopy network.

In terms of consumer representation - I have attended the chairs of these networks' meetings. They conduct their own network meetings and then bring through the critical issues to them, most of which has been around, 'How do I formulate a business case to get a particular business change or a procedure change in the hospital?' that they would like to implement. For example, my understanding from memory, is that we also have a pain management network that is very good at identifying ways to try to alleviate elective surgery waitlists and times, and to better manage pain for people who are waiting, for example, for orthopaedic surgery.

The consumer engagement is actually right across our health committee network. For example, the minister only just this week attended our consumer forum that was run in Campbelltown.

Mr ROCKLIFF - The consumer networks are based on all three regions of the state. They have a lead chair in each region.

On Wednesday I was in Campbell Town to address the whole three regions. Clinicians were also involved in that. They are forthright in expressing some of the challenges they see within the system. I look forward to meeting them more regularly and sitting down one-on-one as well.

Ms MORGAN-WICKS - To clarify my previous answer, our clinic networks were established in 2017. I mentioned the statewide surgical and perioperative services advisory group. I am familiar with them because I have attended and been invited to attend several of their network meetings, particularly with the four-year elective surgery plan. I have met with the chairs of each of these other networks, the Tasmanian endoscopy network, the Tasmanian cardiac network, the Tasmanian stroke network, the Tasmanian pain network, the Tasmanian critical care network and our Tasmanian emergency care network, which I spoke about previously.

When they identify particular improvements they would like to roll-out, adopt new technology, or a change in the way they would like to provide their services, they will engage with consumer representatives on those improvements. We have consumer and community engagement councils which we fondly refer to as our CACECs. Last week I met with the chairs of our CACECs to hear from them the initiatives they are undertaking in each of their regions. There is also Health Consumers Tasmania, whose CEO Bruce Levett is very active and who we are in frequent contact with. Each of our hospital executives also have engagement with consumers. For example, the LGH executive has the chair of their regional consumer and community engagement council attend executive meetings so that they stay on top of what is occurring in those hospitals.

CHAIR - The one in the north-west has people from the west coast, people from Circular Head, usually the noisiest people -

Ms MORGAN-WICKS - Very active.

CHAIR - Very active, yes. They come up with some good ideas. They are mostly constructive. We will move to recommendation 8. I think we have covered this one. This is about action on outstanding recommendations from three reviews. You have said you've pulled together even more than that.

Mr ROCKLIFF - Going back two decades.

CHAIR - Yes. Is there anything in addition to what you have described earlier in relation to this?

Mr ROCKLIFF - No.

CHAIR - It is well covered. Recommendations 9 and 10. This is the development of the revised THS performance network and strength and performance monitoring and reporting. You mentioned in the response the Department of Health has developed a revised THS performance framework. Is the framework available to look at? I looked on the website but I couldn't find the document that it was referring to? Is it available on the website? It's not. That's why I couldn't find it then.

Mr ROCKLIFF - We can table this for you. The THS performance framework 2021-22.

CHAIR - Thank you.

Ms MORGAN-WICKS - Would you like me to say something about -

CHAIR - A bit of a description about it would be helpful.

Ms MORGAN-WICKS - The Department of Health developed a revised THS performance framework in 2018-19 aimed at strengthening performance monitoring and reporting at a local level, supporting local decision making and accountability while also maintaining state wide strategy and planning within a single health system. It was developed in consultation with the THS. It is structured around six domains of performance as set out in the Australian Health Performance Framework or the AHPF. They provide a cross-linking and mutually supporting view of health performance. The key performance indicators for each performance domain have also been developed according to the principals of AHHPF.

CHAIR - Are the key performance indicators in that document?

Ms SEARLE - No, that's outlined in the performance framework. The key performance indicators are in our annual service plan.

CHAIR - Is the annual service plan published on the website?

Ms SEARLE - Yes, the service plan is tabled in parliament as well.

Ms MORGAN-WICKS - In August 2021 our Performance and Forecasting Committee, which sits as an executive subcommittee, endorsed a revised performance framework which has just been tabled. That recognises the various forms of performance intervention which occur across the system at operational system and executive levels. It also identifies the key expert stakeholder groups who are responsible for implementation of performance interventions. In 2021-22 we have also committed to conducting bi-monthly performance deep dives to ensure that the appropriate level of performance intervention is occurring in accordance with this framework.

CHAIR - There are a lot of figures in the Auditor General's report that outline data collected by the Audit Office from the THS - figures 2-15 with the exclusion of 9. Is it possible to get charts that update those figures? It would show how things may be changing, acknowledging that COVID-19 would have had an impact on that.

Mr ROCKLIFF - They go up to 2017-18.

CHAIR - We can put this in a letter to you if it is too big a task or too difficult to do. These were produced by the Auditor-General from information provided by the THS. You would get the continuum. We will write to you and ask that.

Mr ROCKLIFF - Please write to us. We will provide those figures if we still collect the data in a similar way as presented by the Auditor-General's report.

CHAIR - It is not going to be meaningful if the data is not the same or reported the same way.

Mr ROCKLIFF - Some of that data is nearly four years old.

CHAIR - It would have been 2018 when it was collected…

(THE WITNESSES CONTINUED WITH THE REVIEW OF AUDITOR-GENERAL'S REPORT NO. 1 OF 2016-17 AMBULANCE EMERGENCY SERVICES)
