14th May 2015

The Honourable Michael Ferguson
Minister for Health
PO Box 537
Launceston, Tasmania, 7250

Regarding: Further comment on White Paper – Exposure Draft

Thank you for the opportunity to make a further submission in response to the draft white paper particularly as it concerns the provision of Maternity (or Obstetrics & Gynaecology) services in NW Tasmania. I commend your aim of trying to create a unified, efficient, cost-effective and safe Tasmanian Health Service. We all want that. We all understand the evolving challenges in health care and that a response to this and careful planning is needed. I am motivated to make this submission because of the following:

- I would like to make some constructive suggestions before it is too late, before the May 15th deadline for submissions, as you have invited us all to do. There is no perfect model or system of healthcare. For example, centralisation of health services has the potential advantages of bigger teams, economy of scale, adequacy of clinician caseload and teaching but it also has serious disadvantages and we have all seen these, such as bed block, regular cancellation of booked cases, demoralised staff and, on the flipside, the provinces and rural areas becoming less safe as local clinicians become deskilled and leave rural areas, or the areas experience difficulties recruiting staff or there are transport problems and unsafe delays in transport to central facilities:
    - If the maternity service has to be consolidated in NW Tasmania I believe the Mersey hospital should be seriously considered as the appropriate site because of our good existing unit, our excess capacity and the fact that all of our critical maternity facilities are either brand new or renovated (e.g. the brand new nursery for neonates)
    - It may not be possible or wise to consolidate the maternity service to one unit in NW Tasmania at this time and it may make more sense to continue on for now with the two maternity units, which are of identical capacity and are already doing the work, and to share the Maternity work between them rationally.
    - The government should consider building a new regional hospital that is central in the NW to where patients & staff live. If there had of been some strategic planning 20 years ago we would not be in the difficult situation that we are today. I refer you to an article in the Advocate, Thursday, August 7th 2014, which was an interview with Mr Groom, the state health minister at the time the decision was taken to build the current Burnie hospital. In this article it states that, in 1986, the Liberal government received a report recommending a single base hospital in the NW. It goes on to say that at that time, 1986, the chairmen of the all the area local hospitals discussed the plan for a new NW regional hospital and that "...after extensive consideration it was agreed a central site at Ulverstone was the best option for a new regional hospital." In this article Mr Groom is quoted as saying "We did it [the current Burnie hospital] cottage industry style, on only one level, and the idea was that it could always be sold off at a later stage in future planning and it

could have been a supermarket or something else." If you look at a map of NW Tasmania you will see that Ulverstone is about half way between Launceston and Smithton and about half way between the airport at Devonport and the airport at Wynyard.

  - In all the years that proponents of the Burnie centralisation model of maternity care have been criticising the Mersey hospital, they have done nothing to increase the capacity of the maternity service at Burnie or to provide a solution for the efficient transport of labouring women from the Devonport end of the service at all hours of the day and night, in all weathers and under emergency conditions. We have not seen a single proposal as to how the current Burnie hospital is going to increase capacity to efficiently handle the extra patients currently receiving their care at the Mersey hospital. Several times last year the Burnie hospital maternity unit went on bypass and their patients were transferred to the Mersey hospital. So if Burnie cannot cope with their maternity caseload now, how are they going to cope if a decision is made to consolidate the maternity service in the NW to the Burnie hospital? All the maternity care at the Burnie hospital is provided by a private health care group and obviously they are not going to spend an extra cent on increasing their capacity until they have a decision from government and even then, where is their physical capacity for expansion?

- Now that the Mersey hospital has been upgraded I believe that it should continue as a functioning hospital, with 24-hour anaesthetic, paediatric, HDU and laboratory cover. I cannot see the point of upgrading the hospital to make it a day-surgery hospital and I question where this idea came from and what modelling has been done to support this idea. I wonder about the wisdom of trying to force the Mersey hospital into a fixed model of healthcare. For example, I have been told that the HDU may continue as a 23-hour, short-stay unit. I believe that a staffed, overnight ward will still be needed for those patients having their "day-surgery" operations later in the day (afternoon or evening). So to what extent is this just a re-branding exercise rather than a fundamental, cost-effective change and, is it safer? I do an afternoon operating list here at the Mersey hospital now and a lot cases booked as day cases end up being admitted overnight because, currently, our day surgery unit closes at 6pm and inevitably, there is a wide variation in the way individual patients recover from surgery. I have been told that the day-surgery concept is based on turning patients over within 23 hours. So the previous lot of patients have to be pushed out the front door by 6am so that the next lot can get in for their day-surgery. Will this work? What are the potential pitfalls here? I can certainly think of some. For example, dangerous, dark roads in winter, sometimes with dense morning fog and ice. Another might be that many patients coming for day-surgery will be elderly or overweight and some of these patients will decompensate during their day-surgery procedures. For example, elderly patients with fluid & electrolyte disturbances after bowel preparation for colonoscopies, or cases of bowel perforation or those patients who coincidently have myocardial infarctions or sleep apnoea during their theoretical 23hr day-stay. So I question the wisdom, given that the Mersey hospital has now been extensively upgraded and given that we already have a good, functioning hospital, of trying to downgrade it to a day-surgery hospital, when it may be safer and more sensible to simply add or upgrade the capacity of the current hospital to do more day-surgery. To what extent is the change an exercise in rebranding and where is the

thorough modelling and research that has been done in support of the Mersey hospital becoming a day-surgery centre? So, given that it seems that the Mersey hospital will continue on with staffed wards overnight and a staffed short-stay unit and, as you have been quoted in the press as saying, a 24hr emergency department, why not just continue the hospital on as it is now? Why not just increase the day-surgery efficiency and throughput as you are planning but keep the capacity to do standard operations such as laparoscopic cholecystectomy and hysterectomy (that require overnight stay) that we are doing now and keep the maternity unit (with more of an equal share of cases between Mersey & Burnie hospitals) and keep the HDU which is renovated and doing a good job.

- I wonder, if the Mersey hospital is closed or downgraded, whether people will look back in 10 years time and regard the closure as a false economy. Will it be more costly in the long run to put off planning and building a new, central hospital in the NW, than it will be to continue with the current white-paper plan and transporting patients all around the state? In the time that closure or downgrade of the Mersey hospital has been mooted (newspaper articles going back to at least 2005) I have seen many new hospital developments around Australia started and completed. A brand new multistorey dedicated women's hospital and a new children's hospital have opened in recent years at the Mater Hospital in Brisbane. In central Melbourne a new women's hospital and a new children's hospital have been built and opened. The Fiona Stanley Hospital in Perth is now open and the St John's group in Perth have just finished building a new hospital in Midland . The Canberra Hospital added a new women's hospital wing. Big new hospitals are going up on the Sunshine coast in Queensland. These are just the ones I have seen myself. So it seems that all around Australia, over the past 10 years, a massive amount of new hospital infrastructure has developed. So I would hope that the Tasmanian government starts planning for a new greenfields hospital to be built centrally, on flat land in NW Tasmania. It is not unreasonable to plan new hospitals particularly as the NW does not currently have an appropriate, central, regional hospital. Until such time as this new hospital can be built I urge you to keep both the Mersey and the Burnie hospitals open and to be decisive about this to provide some certainty (and therefore, safety) to the area.
- There is always an alternative point of view or option and hopefully, by having a range of views, some of the pitfalls in and adverse outcomes of health service planning may be avoided.
- Health service planning is often done in abstract and centrally but local knowledge may help to increase the likelihood of success
- There is always potential to make the situation worse with any changes. What works elsewhere or what sounded like a good idea, may not necessarily deliver the safety and quality and efficiency outcomes in this area of NW Tasmania, at this time. This may be because of naivety, lack of local knowledge, poorly evidenced planning, the law of unintended consequences, the short political cycle and the particular quirks of NW Tasmania or simply because of an inappropriate attempt to make a fixed ideology of health care fit all settings.
- I hate to see good infrastructure and good staff and a good working hospital downgraded. It is a waste of good infrastructure, particularly as the Mersey hospital has been undergoing continuous renovation and upgrades over the past year. Working here for the past year, you would think that the Mersey hospital was being prepared for a bigger, longer term role, not

a reduced one. Completely new fire systems have been installed, new security doors, new parking areas and new flooring are just some of the improvements.

- It is apparent from comments attributed to you in the press that a lot of misinformation about the Mersey hospital has been given to you and I would like to provide an alternative view as it applies to the Maternity unit. We accept that government has a responsibility to run the health system efficiently but please be very careful about making decisions on questionable safety hearsay. Health professionals everywhere take pride in their work and I challenge you to demonstrate to us compellingly that our safety record and outcomes in the Maternity unit at the Mersey hospital are any worse than they are, for example, at Burnie, notwithstanding the risk stratification in the area service plan. Every hospital on the planet has complications and adverse outcomes. I have attended NW area M&M (Morbidity & Mortality) meetings regularly for the Obstetrics & Gynaecology service over the past two years and I am not aware of any fundamental difference in outcomes between the Mersey hospital and the Burnie Hospital.
- If there was a modern, purpose-built hospital in the NW, on flat land and central to where patients and staff live then it would be easy – everyone would be happy to have a consolidated Maternity unit. But there isn't. We have two hospitals of identical capacity at either end of the NW area. It is controversial whether the hospital at Burnie is central to the NW area and I have previously described the limitations of the Burnie hospital as a proposed regional hospital. Many times I have done the drive between Latrobe and Burnie and Launceston and Smithton and I have tried to reconcile how consolidation to one hospital might work and I have not been able to do this. They are just too far apart and unfortunately, the Burnie Hospital is actually located in the suburb of Cooee, on the Cape Grim side of Burnie, half way up the side of a hill and now built out by private dwellings and, coming from Devonport, requires travelling across the city of Burnie, at city speed limits, through traffic lights, to reach it. It is a very odd place to put a hospital and if Mr Groom has been quoted correctly in the Advocate article mentioned above, it was never designed as the definitive, central, regional hospital for the NW. When I have asked older colleagues or locals why the Burnie hospital was built in such an odd place I have frequently been told something like "because there was some vacant land there". Well, if true, that represents an extraordinary level of strategic planning doesn't it? Yesterday, I drove from Latrobe to Wynyard to fly to an outreach clinic on King Island. It was a very blustery, cold, rainy, winter's day, with the car being buffeted alarmingly. The pilots did a very skilled flying job. Driving back to Latrobe in the evening the conditions were still the same and I thought how a woman in rapid labour at 2am, who lives in Shearwater, would make it to Burnie in these conditions and it is very worrying. For a few winter months every year in Tasmania it gets dark very early, there are strong winds and sometimes dense morning fogs and the roads are wet and icy. I worry about this in the context of plans for centralisation of maternity services and the proposed plan to transport day-surgery cases to the Mersey hospital from all around the state particularly when we have existing infrastructure where the work is already being done and services are available.
- The evergreen contract for both the public & private maternity service, held by the private hospital group at Burnie seems to be problematic and an ongoing barrier to progress:
    - There is concern about integration of the service with the rest of the state particularly as the Hospital has its own set of protocols and paperwork independent

of the rest of the state and is not linked in with other health services around the state via the digital medical record (DMR). This situation is typical of purely private hospitals but the problem in the Burnie context is that the private health care group has been given responsibility for the management of all the maternity patients, both public and private.

- There are issues with the after-hours service provided at the private hospital and the efficiency with which emergency maternity cases can be dealt with
- Ironically, although it is a private health care group and profits from providing the maternity service at Burnie, it does not provide a private maternity service to those women who are privately insured (or elect to pay) and want private obstetric care and choice in their health care.
- You will often hear it said that the NW area cannot attract a permanent obstetrician. The main reason for this is the ongoing uncertainty regarding the location of services and the area plan and the fact that a private component of Obstetric practice has been actively discouraged. Given that private care is available in other areas of surgery & medicine in the NW, such as daytime anaesthesia, orthopaedics and ophthalmology, this seems discriminatory towards women in the area and Obstetricians with an interest in working in the area.

- Like many of my professional colleagues I am unhappy that the government describes the Tasmanian health system as "broken". It is not broken. We all understand what you mean, that the current system is not perfect and there are continuous challenges which require a response but it is incorrect and demoralising to describe the Tasmanian Health system as broken. In historical terms the health and longevity of Tasmanians is relatively good. Every day, hard-working professionals around the state go to work and look after patients and take pride in their work and strive to be better and I think that there are many more satisfied patients than dissatisfied ones. Is our education system broken because of the continual controversies surrounding the content and delivery of education? Is our security and policing system broken because there is ongoing debate about the settings between fascism and anarchy? Single word slogans that are not true are unhelpful and unfair. However, there is certainly potential for government to "break" the health system by naive, poorly evidenced planning, ignorance of local conditions, a fixed ideology of health care and a lack of strategic planning. Hospital staff here in the NW are demoralised and depressed because of the continual indecisiveness of government and lack of strategic thinking . Staff are leaving and it is hard to recruit new staff. Locum rates are high which is inevitable because of the uncertainty. This has a flow on effect to teaching and mentoring of the next generation of health professionals. All around, it is very damaging.

<u>The capacity of the Mersey hospital and Burnie Hospital</u>

The Mersey hospital has 4 birthing rooms. The Burnie hospital has 4 birthing rooms
The Mersey hospital currently has excess capacity whereas the Burnie hospital has none and sometimes has to go on bypass with patients being transferred to the Mersey hospital
The Mersey hospital has a renovated birth suite, a brand new, purpose-designed Level 2 nursery for neonates (that has not been used for lack of staffing), a good maternity ward and a renovated HDU which has a modern, purpose-designed isolation room for infectious patients.
Currently, we have 24hr specialist anaesthetic cover, 24hr operating theatre availability and a 24hr laboratory.

We can get women into our operating theatre for emergency caesarean sections and gynaecology emergencies, 24/7, at least as quickly as the private hospital at Burnie
The Mersey hospital operates as part of the DHHS (although federally funded)
The Mersey hospital has state-of-the-art electronic medical records, directly linked to Hobart. This system, that I use every day, in the clinics, on the wards, in theatre and in my office, is the best I have used in any Hospital in Australia and allows me to view all of my patient's radiological films quickly, on the computer, and to manage them efficiently with electronic records and communication.
I am not aware of any fundamental difference in safety or complication rates between the maternity units at the two hospitals
The Mersey hospital is on flat land with adequate parking and is not built out and there is room for expansion and it is located on the major highway and easily accessible.
There is a plan to develop the city of Devonport which is the Ferry terminal for tourists coming to Tasmania and around which new suburbs are developing
The premier, the Honourable Will Hodgman, has stated that he wants to see the Tasmanian population increase by 50% to 600,000 and if this occurs, more hospital infrastructure may be needed not less

The 23 hour day-surgery model

Will it work? Will it work in Tasmania using the Mersey hospital at Latrobe? Where is the detail and modelling in support of this? Can you direct me to a website or link where I can see all this modelling? You have stated publically that you are very confident that patients resident in Hobart, who have been waiting for a long time for their operations, will be very happy to travel to Latrobe, to the Mersey hospital, to have their operations. What market research has been done in support of this assertion? Was a formal market survey of waiting-list patients done in Hobart? What attention has been paid to the detail regarding the logistics of managing day-surgery patients travelling from all around the state to the Mersey hospital at Latrobe? What allowance has been made for poor weather and road conditions in winter? Where can I go to find the modelling that has been done to support the proposed changes to the Tasmanian Health Service? Where did the idea come from in the first place? What makes you think that turning the Mersey hospital into a day-surgery hospital is a good idea or will work? I would assume that extensive costing and modelling has been done regarding how many new ambulances will be needed to transport emergency cases and how many general transport crews will be needed to transport elective surgery patients. Will these patients be confident to travel to the NW for their care particularly in the winter months when it is dark at 5pm and the roads are wet and icy and subject to native animals crossing and particularly if they are being discharged from hospital at all hours of the day and night? If there are a lot of teething problems with this plan or other hitches and the public lose confidence in the idea then the whole plan could fail. So where is the modelling and statistical work that has been done on this? Currently we do have a working system. It is not broken. However, there is the potential to make it worse through poor planning and the law of unintended consequences or simply by trying to force an inappropriate idea on existing infrastructure instead of having a medium-long term plan such as building a new, central hospital in the NW. Where is the detail around the selection of patients to travel for their day-surgery operations at the Mersey hospital in Latrobe? Who will screen the patients for this? What about overweight patients? Will there be age limits? By the time all of this screening has been done, will there be any patients left who are candidates for travelling across the state for their day-surgery at Latrobe and will this be cost-effective or not? What is the definition of a day-surgery hospital and will the Mersey hospital fit this? What other day-surgery hospitals can you show us that are like the Mersey hospital may become if the draft white paper is enacted, that is, a day-surgery hospital which has its own current critical facilities stripped out but is an hour away from other critical facilities at Launceston and 3 hours away from those in Hobart (and that is in good weather).

Opportunity to run the Mersey hospital independently and rationally from 1st July 2015

During the time of the THO-NW, the parochialism and competition between the Burnie hospital and the Mersey hospital has been unhelpful and a barrier to progress and efficiency. You have provided a document to the Tasmanian public called "A single Tasmanian Health Service Fact Sheet" which is available via https://www.dhhs.tas.gov.au/onehealthsystem. The following are some direct quotes from you in the factsheet:

"We will move from three Tasmanian Health Organisations (THOs) to a single THO – to be called the Tasmanian Health Service, by 1 July 2015."

"The change from 'Organisation' to 'Service' reflects the Government's focus on reducing bureaucracy and delivering better health services to Tasmanians."

- *"the establishment of a single state-wide delivery structure designed to improve the coordination of services and reduce duplication in both administrative overheads and clinical support services,"*

"• a single Governing Council, comprising a chairperson and skills-based members, with a spread of regional representation,"

I commend your publically stated aim of reducing red-tape and the health bureaucracy and to have one central administration based in Launceston. The proof that extra bureaucracy does not work is the THO-NW. Years after the THO-NW came into existence the NW health service is in a demoralised, uncertain state, just as bad as at any time in its history. So there is now an opportunity to run the Mersey hospital rationally rather than as a poor relation of Burnie. The Mersey hospital is approximately equidistant between the Burnie Hospital and Launceston in travel time. There is no compelling reason that I can see that the Burnie and Mersey hospitals have to be lumped together administratively. However, I question how this administrative change is going to be transitioned and your ability to see this through and to actually reduce red tape. Like the situation with the 23hr, day-surgery hospital concept, could your plan to reduce the health service bureaucracy just end up as a superficial rebranding exercise, with business as usual for the 3 current THOs? Are you, in fact, inadvertently adding red tape and bureaucracy to the health service by keeping the 3 THOs but under a different name and adding a fourth tier of bureaucracy based in Launceston? On the 22nd April 2015 we all received a letter from the Chair of the Tasmanian Health Organisation written on a THO-NW Governing Council letterhead . The subject of this was to advise us all about the "Formation of a Quality and Safety Sub-Committee of the Governing Council". This is approximately 10 weeks before the THO-NW becomes redundant according to your own timetable as described above. In this letter it states that the first meeting of the sub-committee was held on 17 March 2015 and that "Finalisation of the Sub-Committee's terms of Reference is underway...". So it seems that this committee has had its members selected and has already met before the terms of reference for the committee have been decided and 10 weeks prior to the THO-NW becoming redundant. So who selected the committee members and appointed them before it was known what expertise would be needed and, how many quality and safety committees does the Tasmanian Health organisation need and, is this just a rebranding exercise whereby the THO-NW continues after 1st July 2015 but under another name? So can I ask, what is your strategy for the quick, efficient administrative change at 1st July 2015 and do you have an audit process in place whereby you can monitor how successful you are at reducing the red tape? Some of the other statements in the letter seem extraordinary to me in the context of your current white paper process and suggests that there are parallel administrative universes. For example, it states that the THO-NW has formed an "action plan" which will "...help us understand how our community and hospital services might work...". It states that the Governing Council will work to ensure "...organisational stability and effectiveness" and to better describe "...the organisation's roles and engaging our community in a common

understanding about our health service". I ask what "Governing Council" does this letter refer to given your publically stated policy (as quoted above) that from 1st July 2015 there will be a single Governing Council for the single Tasmanian Health Organisation? Do we really need another action plan, another sub-committee and another safety and quality committee and how much more understanding do we need about how hospital services might work before decisive action is taken and a strategic plan agreed?

The Evils of centralisation

There is no perfect model or system of healthcare. You have stated that you want to centralise acute services and provide more community services for management of chronic disease. Centralisation of acute services has many advantages which I acknowledge. These are both economic, with the savings from a reduction of duplicated services, and clinical. Apart from bigger teams, an inbuilt 24/7 capacity with resident professional staff, adequacy of caseload for clinicians and teaching there is the intellectual momentum that comes from having a lot of highly trained professionals in one setting and the ability to do high-tech, expensive, life-saving procedures. However, there is a serious downside to this philosophy of medical care if it is implemented poorly or inappropriately. Bed block is one of these that is commonly reported on the front page of newspapers particularly in the winter months. Not being able to get patients out of overloaded emergency departments and into wards or out of the hospital to make way for the next lot of patients. Regular cancellation of elective surgery cases is another and many times, working in central units, I have seen patients told (and have had to tell them) that their operation has to be cancelled, while they are in the anaesthetic bay on the day of their booked procedure, just about to go in for their operation. These patients have organised their lives, their family and work around their operation and I have seen a public service mentality developing whereby this is now such a common practice in the central units that it is taken for granted by staff and by medical and other students coming through. That is, the next generation of health providers is learning, by example, that this is OK, to treat patients with contempt. Caesarean section rates tend to be higher in the central units, not only because the high-risk cases are referred there but also because of simple time constraints – decisions have to be made quickly and continuously because of overload or potential overload of the central system. Because central units are run very leanly (otherwise there is no cost saving) they often reach capacity and this means that there is simply not the time to practice the art of medicine, to provide individualised care and during busy times, some of the central units have some similarities with cattle markets and some of the women's hospitals are like "baby factories" with patients becoming like cattle or dehumanised units to be pushed out the door as soon as possible so the next lot, who are backed up, can get in. In central units, particularly if they are run too leanly, the outpatient clinics are often so busy that they are chaotic and running two hours late can be the norm. There is no guarantee of increased safety and efficiency with central services. What I often encountered, working in central units, was overworked, demoralised staff who tended to take their maximum sick days and this further increased the burden on the remaining staff and caused more patient cancellations and longer waiting times. Every time a booked procedure is cancelled or a patient procedure is delayed or a patient is kept waiting longer to be seen in a clinic there is potential for harm. This is not safe but is often not audited or recognised. There may be an overall cost saving for the government, with the economy of scale of centralised units but it is not necessarily safer. Overburdened, central facilities can be very dangerous places. They are often staffed by junior staff and staff in training, particularly after-hours. And it is much easier to obscure or dissimulate complications and excuse mistakes in the name of teaching and training or a higher-risk caseload, in big, busy, central, institutions. Preventable complications occur in all the central units as they do in every hospital.

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