Royal Hobart Hospital

ACCESS SOLUTIONS

Occasional Papers

Tasmanian
Government

Foreword

Over the past decade, demand on Tasmania's hospitals has continued to grow, not just in number of patients. We are seeing an increase in the complexity of patients presenting to our hospitals, with more people with mental health and behavioural conditions and complex health issues coming to Emergency Departments.

Significant financial and human resourcing has been invested to meet this growing demand, with increasing numbers of inpatient beds around Tasmania, and growth in the medical specialist and nursing staff numbers in our Emergency Departments and across our hospital system.

If we had the same number and complexity of patients today as we had a decade ago, we would have a far better performing health system than we did at that time. But growth in the demand and complexity of patients has outstripped these investments and our system performance has deteriorated, with people today waiting longer for care in our hospitals.

Our performance is held back in part by the constraint of our physical infrastructure, as we redevelop and expand the Royal Hobart Hospital, but is more starkly impacted by long standing leadership, culture and process issues within our hospital system.

The Auditor-General's recent report notes a perceived "absence of effective leadership within hospitals, THS and the wider health systems as the major impediments to tackling longstanding cultural barriers to change and the dysfunctional silo mentality…which [contribute] to bed block, ineffective discharge planning and bed management, and the ongoing lack of coordination between EDs, inpatient wards and the community".

These issues have been evident for a decade or more and commonly identified through a number of reviews and reform initiatives. It is acknowledged that while the system has been engaged in broad-ranging initiatives to improve patient flow for some time, this has not been reflected in improvements in the patient journey. This suggests that the initiatives have been ineffectively or incompletely implemented, with these issues easy to identify but ultimately very difficult to address.

In large part, these issues haven't changed over the past few years – but they are more visible and more important than ever before as we face the challenge of caring for increasingly complex patients, within fixed physical infrastructure.

Twelve months ago, the Tasmanian Parliament legislated reforms, supported by all political parties, to clarify and strengthen accountability in Tasmania's health system. Under these changes, the Secretary of the Department of Health is now the single point of accountability for the management and delivery of healthcare, and stronger local leadership teams at our hospitals.

As identified by the Auditor-General, urgent action is needed to leverage these reforms and further strengthen whole-of-hospital and system–wide leadership, coordination and accountability for addressing the longstanding cultural and process barriers to improving patient flow.

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We want to take action to improve patient flow, with better discharge planning and coordination with primary and community care services to improve the patient pathway through, and appropriate and timely exit from, our hospital system. This will mean better patient access to our inpatient services.

To achieve this, we need to ensure we empower everyone in our hospital to drive whole-of-hospital efficiencies and process improvements that will lead to better patient access. Local operational decision making together with real local accountability is crucial to improving patient access and flow.

This compendium of occasional papers provides a wide-ranging overview of the issues impeding patient flow and access in our health system, to inform the Access Solutions Meeting on 19 June called by the Minister for Health and the Australasian College for Emergency Medicine.

The Access Solutions Meeting brings together the key stakeholders and participants in our health system, including clinicians and staff providing frontline care in the Emergency Department, senior THS and Departmental leaders, Government leaders and representatives of the opposition parties, professional organisations, colleges and health consumers.

The Access Solutions Meeting will provide an important opportunity for key stakeholders and participants in our health system to establish a shared understanding of the basis and nature of the challenges we face. We must look forward and work together to identify solutions with the resources and facilities we have, and deliver concrete actions.

Collectively, we owe it to Tasmanians to finally make headway on the long-term challenges and culture which have eluded reform for many years and held our health system back from providing better, timely care for Tasmanians when they need it.

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Improving Patient Flow
– Principles, Priorities
and Key Actions

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Overview

Patient flow is the ability of the healthcare system to facilitate flow through the system in order to provide the right care in the right place and at the right time. For an ED, patient flow includes patient access to the ED, flow through the ED, and departure by admission, transfer or discharge from the ED. For the broader hospital, patient flow represents the movement of patients through the facility, culminating in completion of the episode of care, and discharge or transfer.

From a system perspective, for each patient presentation there are three distinct phases within this journey:

- **Input**: how and why the patient arrived at the ED.

- **Throughput**: how they travelled through the various hospital departments (including the ED). Within the ED this phase has a number of components. These include triage (prioritisation based on clinical urgency), placement in treatment area and assessment, diagnosis including necessary test, treatment, and planning including the disposition decision. Factors such as health workforce, staff schedules and ratios, ED layout, communication systems and diagnostic and specialist services availability affect this phase of care.

- **Output**: how the patient is discharged from the hospital. For the ED, for those patients not being discharged, this phase also relates to the ability to move patients out of the ED into inpatient areas.

Where the capacity of a hospital's inpatient services cannot meet patient demand, patient flow is interrupted and the following interrelated issues can occur within the ED:

- *Access block*: the proportion of admitted patients for whom the total ED time (or length of stay) exceeds eight hours. This includes patients who were planned for an admission, but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED[1]. Access block is the principal factor contributing to ED overcrowding[6].

- *ED overcrowding*: where the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure, exceeds either the physical or staffing capacity of the ED[2]. ED overcrowding is most strongly associated with excessive numbers of admitted patients remaining in the ED instead of being transferred to an inpatient bed when their emergency care is completed. This negatively impacts patient safety and quality of care and increases the risk of adverse

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[1] Australasian College for Emergency Medicine Position Statement on Access Block https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx
[2] Australasian College for Emergency Medicine Position Statement on Access Block https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx

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events, violent incidents, errors and near misses, as well as delaying time to definitive care, and increasing excess morbidity and mortality[3,4,5].

- ***Ambulance ramping/ambulance offload delay***: occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, due to lack of an appropriate clinical space in the ED which in turn is affected by access block and ED overcrowding[6].

  Ambulance ramping also indicates acute health care system challenges, whereby patient demand exceeds hospital capacity, as evidenced by access block and ED overcrowding. Adverse patient outcomes, poor patient experiences and higher health system costs are associated with ambulance ramping.

The prevalence of access block, ED overcrowding and ambulance ramping is indicative that delays in patients moving from ED are associated with poor patient flow. These issues can compromise patient and staff safety, contributing to poor patient outcomes. They also decrease the capacity of the ED with the flow-on effect of reducing the ability for staff to assess and treat new patients, further exacerbating the impacts of growth in demand for ED services.

Key Issues and Current Challenges

There have been a number of papers, reviews, analyses, audits and recommended improvement strategies relating to ED performance, patient flow and hospital performance both across the Tasmanian health system and specific to the RHH. These include:

- The Richardson Report (2004)

- Tasmania's Health Plan (2007)

- The Monaghan Review (2012)

- The Commission on Delivery of Health Services in Tasmania (2014)

- One State, One Health System, Better Outcomes – issues, green, white and supplementary papers (2014)

- One State, One Health System, Better Outcomes – Patients First Stage 1 (2016)

- Staib, Sullivan and Timms (2016)

- Patients First Stage 2 (2017)

- Review of Ambulance Tasmania (2017)

- Auditor-General's Independent Assurance Report (2019).

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[3] Richardson DB and Mountain D. Myths versus facts in emergency department overcrowding and hospital access block. Med J Aust 2009; 190 (7): 369-374.

[4] Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust 2006; 184(5):213-216.

[5] Jeanmood, D and Jeanmood, R 2018. Overcrowding in the Emergency Department and Patient Safety. Vignettes in Patient Safety, Vol 2. Intech

[6] Australasian College for Emergency Medicine Position Statement on Access Block https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx

Broadly, these works acknowledge that access block and overcrowding are system issues, not merely ED problems, and causes and solutions largely reside outside the ED, requiring a system-wide and whole-of-hospital approach.

The delay in accessing inpatient beds due to a 'difficult ED-inpatient interface' and delayed discharges that are reducing access to inpatient beds has been commonly identified as the main impediment to timely care.

Common barriers to moving patients out of the ED include poor access to inpatient beds due to inflexible systems or inadequate planning, inadequate specific bed numbers to cater for special needs, overreliance on intensive care/ high dependency beds, or delays in discharging patients to post-acute facilities and the community.

The need to use data to drive continuous improvement was also a key theme, including using the best available data to inform clinical decision making, benchmarking performance data, and making it available to staff to monitor and guide clinical redesign and investment in systems and processes to collect and disseminate new and existing data. An increased focus on measures of overall quality of care rather than process-related hospital efficiency measures was also recommended.

Cultural barriers and the role of clinical leaders in addressing hospital-wide patient flow issues was consistently highlighted, as was the need to clarify and embed roles, responsibilities and accountability at both individual and system levels. This was in relation to implementing identified change initiatives, and ongoing continuous improvement in patient flow.

Key themes for improvement across the phases within the hospital care pathway included (but were not limited to):

Input initiatives

- delivering improved care and care options in the community to reduce reliance on the hospital system

- promoting alternatives to EDs such as general practice and other primary care services

- exploring the use of Urgent Care Centres

- moving to secondary triage – where the triple zero call centre can, where appropriate, direct non-acute patients to other more suitable primary and/or community health providers

- better use of Extended Care Paramedics and Intensive Care Paramedics to increase treatment options for non-acute patients and reduce the need for unnecessary hospital transport.

Throughput initiatives

- improving coordination between ambulance, the ED, inpatient areas and the community

- increasing bed numbers and physical space - both ED and in-patient (acknowledging that without concurrent system improvements this will not solve the issue)

- increasing hospital capacity through better bed management, reducing the average patient length of stay and improving bed turnover

- improving admission process from ED to inpatient beds, including admission decision authority for senior ED clinical decision makers, and consistent admission and clinical handover policies and protocols

- effective use of hospital escalation and capacity management strategies and protocols

Output initiatives

- improving inter-facility communication and protocols, including handover protocols

- improving discharge planning through initiatives such as early discharge planning, review of criterion-led discharge practices, consistently including estimated date of discharge in Patient Flow Manager, improving the management of very long-stay patients, and timely discharge summaries.

While the system has been engaged in broad-ranging initiatives to improve patient flow for some time, this has not been reflected in improvements in the patient journey. This suggests that the initiatives have been ineffectively or incompletely implemented.

Where to from here

In the provision of healthcare there is often tension between the goal of an individual clinician (usually to provide high quality care to an individual patient) and the goal of the healthcare organisation (broadly to provide timely and efficient care to as many patients as possible). If we are to place the interests of patients at the forefront of every decision, then the provision of focussed care to an individual patient must be balanced with consideration of patient outcomes at a system level.

Patients who require emergency admission to hospital require complex care that may be fragmented, occurring in the ED, across the ED-inpatient interface, and, subsequently, in their destination inpatient ward. There is a clear argument for collective responsibility for patient safety within and across these interfaces. All parts of the system have a role to play in improving patient flow with the overall aim of improving patient outcomes. Without a whole of system approach a disproportionate level of clinical risk will remain within the ED, at the cost of patient safety.

There is a need to reset, consider the opportunities for improving patient flow and develop a cogent, considered, consistent and clear plan moving forward. This includes a clear understanding of what needs to be done, who is responsible for doing it and by when. This should then be coupled with clear accountability structures and ongoing monitoring and measurement to ensure that initiatives are on track and achieving the desired outcomes.

The following principles will underpin these considerations:

- The interests of patients are at the forefront of every decision.

- All improvement will be underpinned by an emphasis on safe, timely and quality care for all patients.

- Regardless of where we work in the system, we have a shared responsibility for patient outcomes across the system, within our facilities, within and across our teams and as individuals.

- Patient flow is everybody's responsibility. We must all, as facilities, teams and individuals, take ownership and responsibility for improving patient access.

- Accountability for implementing solutions will be system and hospital wide.

- A systems approach - solutions will be integrated, not siloed.

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Management of Mental
Health and Complex
Patients in the
Emergency Department

Tasmanian
Government

Key Points

- More people are presenting to EDs with mental health and behavioural conditions and they are waiting longer in EDs for care than other patient groups.

- EDs are now seeing more people with complex health issues.

Demand for emergency care in Tasmanian public hospitals has steadily grown over the last nine years with most of the growth in presentations occurring at the Royal Hobart Hospital.

While this growth in total presentations was lower compared to all other Australian States, Tasmania has a number of unique characteristics that create challenges in meeting this growing demand, including an older and more rapidly ageing population and the lowest average annual income level and a higher rate of dependency on social welfare.[7] These are all factors that can lead to increased complexity associated with patient health issues. Moreover, Tasmanian services are challenged in reforming models of care in line with other jurisdictions compounded with a lack of robust community services to divert demand away from acute services.

EDs in Tasmania are now seeing more people with complex health issues. The Auditor General has highlighted an increase in complexity of ED presentations over the last nine years, observing that an analysis of ED demand factors also forecasts an increasingly more complex and older cohort of patients and growing acuity of ED presentations[7]. There is a growing body of evidence suggesting that the drivers of ED crowding include increasing presentations of elderly patients with complex, multi-morbid conditions[8] .

Along with increased complexity, EDs are also seeing more patients with mental health and behavioural conditions. These patients are also spending longer in EDs waiting for mental health inpatient care[9]. These wait times are disproportionately higher than other patient groups.

The factors highlighted above can lead to poor patient outcomes, ED overcrowding, access block across the broader health system and significant challenges in providing the right care in the right place and at the right time.

These issues require a system-wide and whole of hospital approach underpinned by effective coordination between the ED, inpatient units and the community. Solutions to improving outcomes for these patient groups and reducing pressure on EDs should not solely focus on investment in and clinical redesign of hospital services; solutions should also consider services and initiatives in the community and primary health sector and community based alternatives to hospital care.

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[7] Report of the Auditor-General, No. 11 of 2018-19, Performance of Tasmania's four major hospitals in the delivery of Emergency Department services, May 2019. https://www.audit.tas.gov.au/publication/performance-tasmanias-four-major-hospitals-delivery-emergency-department-services/

[8] Morley, Claire & Unwin, Maria & M. Peterson, Gregory & Stankovich, Jim & Kinsman, Leigh. (2018). Emergency department crowding: A systematic review of causes, consequences and solutions. PLOS ONE. 13. e0203316. 10.1371/journal.pone.0203316.

[9] Australasian College for Emergency Medicine Statement on Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx

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Complex Patients

Complexity in patients can be considered in many ways. A common approach is to consider complexity in terms of co-morbid and multi-morbid patient conditions and the interaction between disease related factors such as diagnosis, severity of condition or symptoms, co-occurring conditions, chronicity and level of disability.[10] Broader approaches to complexity also consider situational complexity and the impact of the patient's context, in particular personal and environmental factors including the physical and social environment in which people live, relationships, social supports.[10] These factors can influence a patient's health condition, functioning and interaction with the health care system either positively or negatively.[10]

At the heart of the concept of complexity is the effect of the interactions of all relevant factors, which can result in patients requiring a higher level of care, and/or requiring the care of multiple healthcare professionals, and/or requiring care for multiple conditions related to their illness. Complex patients are therefore at higher risk of poor health outcomes[11,12,13,14] and their care is more likely to be at higher cost to the system[15,16].

Patients with Mental Health and Behavioural Conditions

The Australasian College for Emergency Medicine (ACEM) paper on waiting times in the emergency department for people with acute mental health and behavioural conditions[17] highlights that, while nationally mental health presentations only account for around four per cent of ED presentations, these patients disproportionately experience access block to mental health inpatient care compared with patients presenting with other emergency conditions.

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[10] Kuipers, P., Kendall, E., Ehrlich, C., McIntyre, M., Barber, L., Amsters, D., Kendall, M., Kuipers, K., Muenchberger, H. & Brownie, S (2011). Complexity and health care: Health practitioner workforce, services, roles, skills and training to respond to patients with complex needs. Brisbane: Clinical Education and Training Queensland.

[11] Bayliss, EA, Bayliss, MS, Ware, JE & Steiner, JF 2004, 'Predicting declines in physical function in persons with multiple chronic medical conditions: What we can learn from the medical problem list', Health and Quality of Life Outcomes, vol. 2, no. 1, p. 47.

[12] Fortin, M, Bravo, G, Hudon, C, Lapointe, L, Almirall, J, Dubois, M-F & Vanasse, A 2006, 'Relationship Between Multimorbidity and Health-Related Quality of Life of Patients in Primary Care', Quality of Life Research, vol. 15, no. 1, pp. 83–91.

[13] Guthrie, B, McCowan, C, Davey, P, Simpson, CR, Dreischulte, T & Barnett, K 2011, 'High risk prescribing in primary care patients particularly vulnerable to adverse drug events: cross sectional population database analysis in Scottish general practice', BMJ, vol. 342, p. d3514.

[14] Read, JR, Sharpe, L, Modini, M & Dear, BF 2017, 'Multimorbidity and depression: A systematic review and meta-analysis', Journal of Affective Disorders, vol. 221, pp. 36–46.

[15] Wang, L, Si, L, Cocker, F, Palmer, AJ & Sanderson, K 2018, 'A Systematic Review of Cost-of-Illness Studies of Multimorbidity', Applied Health Economics and Health Policy, vol. 16, no. 1, pp. 15–29.

[16] Wolff, JL, Starfield, B & Anderson, G 2002, 'Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly', Archives of Internal Medicine, vol. 162, no. 20, p. 2269.

[17] Australasian College for Emergency Medicine, Waiting times in emergency departments for people presenting with acute mental and behavioural conditions. 2018, ACEM: Melbourne. https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx

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Locally, Tasmanian data shows a 30.6 per cent increase in mental health related presentations to the RHH ED between 2013-14 and 2017-18, from 2 759 to 3 604[18]. Further, the data highlights that not only are more people with mental health and behavioural - related conditions presenting to the ED, they are spending more time in the ED and with less likelihood of admission to RHH inpatient mental health. This is coupled with a rise in inpatient mental health length of stay and a decline in the number of mental health related separations (leaving hospital)[18]. The acute inpatient unit at the RHH has also been experiencing increased rates of occupancy, operating at about 98.2 percent occupancy as at 31 March 2018, and has experienced bed block on a number of occasions during 2017-18[18].

Similar to complex patients, people presenting to EDs with mental health and behavioural conditions are at higher risk of poor health outcomes and their care is also more likely to be at higher cost to the system.

Key Issues and Current Challenges

Complex patients can present to EDs for many reasons. Reasons for presenting may however point to key issues and challenges that warrant further consideration.

Complex patients may present to an ED due to an exacerbation of their health conditions which requires emergency care and/or inpatient care. For this group of complex patients there will be limited scope for diverting care away from an ED. However, improvements to their care coordination within the hospital can be made. Improved patient flow, discharge planning and coordination with primary and community care services can improve their pathway through, and appropriate and timely exit from, the hospital.

Some complex patients may present to an ED although the care required may be best delivered by primary or community health services. Opportunities to improve outcomes for this patient group include initiatives that improve care options in the community and systems and processes that refer and divert to other more suitable primary and/or community health providers rather than being transported to the ED. Further to this, a review of Ambulance Tasmania (May, 2017) noted a significant proportion of patients that call Triple Zero do not require an ambulance response or transport to an ED. Over half (53 per cent) of patients assessed by a paramedic either do not require transport because they can be treated on site or are non-acute. A further 45 per cent are assessed as acute, but not time-critical[19].

Complex patients may also present to an ED due to a failure of care, including healthcare, home care and/or social support services. These patients can also experience increased length of stay when they cannot be safely discharged due to lack of supports.

Opportunities to improve outcomes for complex patients and reduce pressure on EDs include effective care options in the community and better coordination of care between

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[18] Department of Health Internal Data

[19] Report of the Auditor-General, No. 11 of 2018-19, Performance of Tasmania's four major hospitals in the delivery of Emergency Department services, May 2019. https://www.audit.tas.gov.au/publication/performance-tasmanias-four-major-hospitals-delivery-emergency-department-services/

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and across primary, community and acute care services. Some current initiatives being rolled out to improve care in the community include:

- The Community Nursing Enhanced Connections Service (CoNECs) which is a non-admitted alternative for clinical care following ED presentation, assessment and initial treatment that provides enhanced access from hospital EDs to Community Nursing Services. It seeks to provide a person-centred, coordinated approach to the delivery of clinical care following ED presentation to maximise both patient and organisational outcomes across the care continuum. Services are provided seven days a week, 365 days a year predominately in Community Nursing Clinics. However, people unable to attend due to their condition, may be seen within their usual place of residence, including home, supported accommodation, or residential facility.

- The Community Rapid Response Service (ComRRS) service established in 2016 to provide quality care in the community for people with chronic and complex illnesses and help to keep them out of hospital. This service provides treatment for people who need short-term intermediate care that can be safely delivered in the community or in the home. It is available to people with acute illness or injury and to people whose chronic and/or complex condition has deteriorated in a way that would otherwise see them present at an ED and possibly be admitted to hospital. The service works on the principle that a patient's care is shared between their usual GP and community nursing and other health professionals. Treatment is being provided wherever it best meets the patient's needs which might be in their home, in a residential aged care facility, or in a community health centre. Following a successful trial in Launceston, the Government has committed to a permanent service for Launceston and expansion of the ComRRS service to the South and North West regions. The services in the South and North West are currently being established.

- Ambulance Tasmania, as part of the Government's commitments to Ambulance Services, is currently establishing a 'Secondary Triage' system where the triple zero call centre can, where appropriate, direct non-acute patients to other more suitable primary and/or community health providers. Related services employ officers that have the skills, systems and support to diagnose the needs of low-acuity patients over the phone and divert them to alternative services that are suited to the patient's needs.

There is still work to be done to ensure that these initiatives are effectively and efficiently implemented, to integrate these initiatives with existing services, and in developing short and medium term solutions while these initiatives come on line.

As noted already in the paper, EDs are also seeing more patients with mental health and behavioural conditions. Patients are also spending longer in EDs waiting for mental health inpatient care[20]. These wait times are disproportionately higher than other patient groups. Delays in receiving care are likely to be indicative of broader systemic issues across and

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[20] Australasian College for Emergency Medicine, Waiting times in emergency departments for people presenting with acute mental and behavioural conditions. 2018, ACEM: Melbourne. https://acem.org.au/getmedia/0857d22e-af03-40bb-8e9f-f01a2a2bf607/ACEM_Mental-Health-Access-Block.aspx

between the care continuum from community based mental health through to acute psychiatric impatient care.

In 2018, ACEM hosted a summit focussing on Mental Health in the ED. The task of the Summit was to set the agenda for policy reform to improve the experiences of people with mental health conditions seeking help from EDs across Australia. The delegates of the summit agreed on seven key principles[21] and priority action areas which form the basis of a consensus statement released in May 2019[22]. The principles focus on patient centred care, prevention and early intervention, timely access to appropriate care, safe supportive and culturally responsive care, minimising length of stay and increased community and inpatient capacity.

There is much that can be done to improve the experiences of people who present to EDs with mental health issues, it is also essential that system responses beyond the ED are improved. This is because the ED is often not the most appropriate place for care provision and spending time in the ED can exacerbate the patient's condition.

This may require review of the manner in which care is provided to ensure that the model is contemporary and built around the needs of the consumer. This includes reorientation towards care that is based in the community and provides timely access to expert, early, intensive and multidisciplinary services. Specifically, improving access to community based urgent care services (as an alternative to the ED) is likely to involve a reconsideration of the role of, and interaction between, helplines, Crisis Assessment and Treatment Teams, Duty Officers, Psychiatric Emergency Nurses and the Mental Health Hospital in the Home service. Recognising and enhancing the linkages and shared care responsibilities between primary care providers and specialist clinical services is also required.

These improvements should not be at the cost of, but rather enhance, the interface between community based and hospital based care (ED and inpatient) to ensure appropriate, timely and safe access to, flow through, and discharge from the acute care system back into the community.

The Government has made investments in many areas aimed at improving mental health care in Tasmania and reducing the focus on hospital based care, leading to better outcomes for patients and better outcomes for the health system. Recent initiatives include:

- New mental health beds, including a brand new 12-bed dedicated mental health facility as St Johns Park in New Town (replacing previously committed 10 beds at Mistral Place), 16 bed Adolescent Unit in the redeveloped RHH to provide space for specialist mental health care for young people and rebuilding the Peacock Centre in Hobart to provide 15 additional mental beds to provide 'step-down' care post-hospitalisation, or 'step up' care for those whose condition has escalated and with a focus on avoiding hospitalisation. These beds are currently under development.

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[21] Mental Health in the ED summit communique https://acem.org.au/getmedia/99ec6be7-bd66-4395-a6bb-3ae76f92461c/Communique
[22] ACEM Consensus statement on Mental Health in the Emergency Department https://acem.org.au/getmedia/0309ba59-d37b-478b-b5c9-e96b272ff837/Consensus-Satement-110419

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- Mental Health Hospital in the Home commenced in March 2019 and is an acute mental health service provided in the Greater Hobart region. The service provides people who are experiencing acute mental illness with care, treatment and support in their own home. Intensive specialist care is provided for up to 14 days. When suitable, this option replaces admission or extended stay in hospital.

The Government has also considered the acute care needs of patients, and the newly released RHH Masterplan re-confirmed the relocation of mental health in-patient services to Levels 2 and 3 of K-Block which have been redesigned to deliver improved outcomes for mental health patients. It has also identified an interim solution to expand the ED in its current location to provide for discrete mental health safe assessment unit and support areas. The Masterplan has also considered subacute and community care and indicates a future stage three of the RHH project to redevelop the Repatriation Hospital as a subacute and mental health campus of the broader hospital facility that will require funding from future budgets. This is in recognition that a purpose-built mental health facility is the preferred future model for inpatient mental health care.

Where to from here

As noted above there are a range of initiatives and Government commitments to improve outcomes for these patient groups. However, many of these initiatives are in the early stages of implementation. As such, there is still work to be done to ensure effective and efficient implementation, to integrate these initiatives with existing services, and in developing short and medium term solutions for these patient groups while these initiatives come on line. To obtain maximum system benefit for all patients in a context of finite resources and provide value to patients and to the Government, appropriate effort must be invested in targeting these initiatives to identified cohorts of patients who represent access risks. The initiatives identified to improve patient flow, governance and accountability across the hospital will also improve outcomes for these patient groups.

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Accountability in
Service Management:
governance,
stewardship of
resources, and
responsibility for
patient care and access

Key Points

- The Auditor-General's Report[23] notes a perceived "absence of effective leadership within hospitals, THS and the wider health systems as the major impediments to tackling longstanding cultural barriers to change and the dysfunctional silo mentality…which [contribute] to bed block, ineffective discharge planning and bed management, and the ongoing lack of coordination between EDs, inpatient wards and the community".

- Our senior leaders have an important role to play in embedding effective governance to support our commitments to deliver better, more sustainable health services for all Tasmanians.

- The Secretary, THS Executive, local leadership teams and our health workforce more broadly have a collective and individual responsibility for driving change as well as a responsibility to build a stronger statewide health system.

- The clinical stream model aims to provide effective clinical leadership to strengthen our hospital management and contribute their expertise to system wide reform. These roles are vital to manage and plan for the increasing demand and complexity of health service provision across streams and across our health system in a context of finite resources.

The Tasmanian Government committed to delivering streamlined governance arrangements for the Tasmanian health system. The commencement of the *Tasmanian Health Service Act 2018* (THS Act) on 1 July 2018 marked the beginning of a new governance model for the administration and oversight of the Tasmanian Health Service (THS). A central principle of the new governance model is to empower local decision making while maintaining state-wide strategy and planning within One Health System.

Local decision making must be equally matched to local accountability. Strong and effective governance leads to better patient outcomes and is a key enabler for the successful implementation of patient flow approaches being rolled out across the health system.

The *Improving Patient Flow* Occasional Paper acknowledges that Emergency Department access block cannot be remedied solely by solutions within Emergency Departments – it requires a system-wide and whole-of-hospital approach. Similarly, the Secretary, THS Executive, local leadership teams and our health workforce more broadly have a collective and individual responsibility for driving change as well as a responsibility to build a stronger statewide health system.

This paper sets out the current context of accountability and governance in the THS and highlights some areas for discussion around identified challenges.

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[23] Report of the Auditor-General, No. 11 of 2018-19, Performance of Tasmania's four major hospitals in the delivery of Emergency Department services, May 2019. https://www.audit.tas.gov.au/publication/performance-tasmanias-four-major-hospitals-delivery-emergency-department-services/

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Accountability and Governance Frameworks

Public sector governance encompasses the responsibilities, practices, policies and procedures that provide state servants with strategic direction, ensure objectives are achieved, and ensure risks are managed effectively and finite public resources are used responsibly and with accountability. Governance can only work if it is part of organisational culture that values accountability, where every employee knows and acts on their responsibilities.

Given the context of the Tasmanian state sector, local decision making needs to occur within the accountability framework set out by the:

- *State Service Act*, State Service Principles and Code of Conduct, and the *Financial Management and Audit Act*

- THS Act, Ministerial Charter and Service Plan

- THS Operational Structure and administrative frameworks, including delegations.[24]

The key accountabilities within the system, and the people or positions to whom they are delegated, are set out below.

The Minister for Health

The Minister for Health represents the Government and is accountable to Parliament and the community for the performance and strategic direction of the Department of Health and the THS. The Minister administers the THS Act 2018, provides broad strategic guidance and sets policy expectations for the THS through the Ministerial Charter, in line with Government priorities and funded initiatives. Each year, minimum performance standards, measures and services to be provided by THS are set by the Minister through the Service Plan.

Secretary, Department of Health

The Secretary is responsible to the Minister for the performance of the THS and THS Executive. The Secretary can give directions to the THS in relation to the performance of its functions and exercise of its powers. This includes issuing policy or directing the THS to undertake actions to improve performance.

Department of Health

The Department of Health is the system manager and purchaser/funder, and is responsible for providing strategic leadership and direction for the delivery of health services in the State, and must have a governance framework of processes, procedures and controls in place to assure the Minister that the objectives of the system are being met.

The Department supports the Secretary to undertake powers and functions in delivering oversight and performance monitoring of the THS.

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[24] Further information on the corporate delegations and administrative authorities that apply within the THS, including human resources, financial and information management delegations, is provided at Appendix 1.

Tasmanian Health Service

In contrast to the Department of Health's role as system manager, the THS is responsible for service delivery. Its primary purpose is to promote and maintain the health of Tasmanians. The THS comprises a collection of public hospitals and health services, organised on a geographic or service basis that together deliver health services and health support services to the Tasmanian community, and train health professionals.

THS Executive

The THS Executive is collectively responsible for ensuring the THS delivers the services set out in the Service Plan, to the agreed volume and performance standards, and in accordance with the budget set out in that plan. They are collectively responsible for managing, monitoring and reporting on the administrative and financial performance of the THS, as required by the Secretary.

The THS Executive is given authority to determine the level of delegation given to each service to enable them to effectively manage the delivery of health care services to the Tasmanian community. In making these determinations, the THS Executive is required to balance the need for local control and management with the needs of the entire health service.

To support this aim, the THS Executive is given authority to set and enforce policy and directions for hospitals, health services and support services under its control. The THS, through its executive, is accountable to the Secretary.

In addition to their THS Executive responsibilities, each THS Executive member holds an Executive portfolio responsibility, with individual accountability to the Secretary for coordinating and managing day to day operations of the THS within that portfolio.

Hospital Level Governance

In 2017, the Government committed to streamline the governance of the THS to remove duplication, improve clarity and transparency and empower local decision making. The governance structure is set out in the *THS Organisational Structure June 2018* and is designed to support the delivery of local services as part of a state-wide health system.

Under this streamlined governance model, two Executive Directors of Operations (South and North/North West) were created reporting directly to the Chief Operating Officer. The Executive Directors have day-to-day responsibility for managing acute hospital operations and for ensuring that the four major hospitals, community and satellite sites are appropriately managed.

To strengthen local decision making the Executive Director of Operations-South established the RHH Executive Committee. The Committee incorporates all Clinical Stream leaders within the RHH, Professional Leads, and representation from Corporate Services and Human Resources. Collectively the RHH Executive Committee is responsible for overseeing performance against agreed standards and compliance with relevant THS, Departmental and Government policies, practices, procedures and codes of conduct. It has a core role to proactively manage risk, including implementing processes to identify, monitor and manage critical risks across the hospital.

The Executive Director of Operations provides the link between the THS Executive and its subcommittees and the RHH Executive.

Clinical Stream Directors – Royal Hobart Hospital

Clinical stream structures are being implemented across our four major hospitals. The clinical stream model has been in place at the RHH since September 2017. Each clinical stream is led by two Co-Directors (a Nursing Director and Clinical Director). Clinical Stream Directors form part of the RHH Executive and report to the Executive Director of Operations.

RHH clinical streams Co-Directors (Nursing and Clinical)				
Acute Medical	Cancer Chronic Disease and Sub-Acute Care	Critical Care, Clinical Support and Investigations	Surgical and Perioperative Services	Women's and Children's Services

While they are not specified in the legislation, Clinical Stream Directors are critical roles in our health care system under the current approach. They are expected to lead change and have critical accountability to ensure systems and services operate within a budget and align with the organisational strategy at their facility and at the state-wide level.

The clinical stream model aims to provide effective clinical leadership to strengthen our hospital management and contribute clinical expertise to system wide reform. These roles are vital to manage the increasing demand and complexity of health service provision across streams and across our health system in a context of finite resources.

As members of the RHH Executive, they have dual roles: management of an individual stream and collective responsibility as a member of the RHH Executive to ensure that, across their clinical streams and the hospital more broadly, resources are efficiently utilised, services are integrated within the hospital and delivered in accordance with hospital policy directions, service standards, financial targets and set budgets. Clinical Stream Directors have been assigned the necessary levels of formal financial and human resources delegations that enable this decision making and to empower them to be leaders of change.

Clinical Stream Directors sit in a unique and critical part of the health system structure. They support the THS and the hospital to deliver its strategic objective of a statewide health system, but also guide and direct the day-to-day delivery of clinical services to patients.

Clinical Stream Directors are therefore perfectly placed to act as stewards for the reforms that need to be delivered to improve patient access and flow across the RHH and the THS more broadly.

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Key Issues and Current Challenges

Historical reviews of health system performance have consistently identified the important role clinical leaders need to play to address hospital-wide patient access and flow issues, and that cultural barriers exist that prevent this[25,26].

The Auditor-General's May 2019 *Independent Assurance Report* recommends:

- "Strengthening whole of health system leadership and coordination of initiatives designed to improve patient flow by clarifying the roles of responsibilities of all Executive Directors of Operations, mental health services, primary and community care leadership teams, inpatient wards, department heads, clinicians, nurses and related administrative and support staff in prioritising and contributing to hospital and system wide initiatives to improve patient flow"; and

- "Ensuring all hospital, mental health and community care leadership teams, department heads and their staff are fully empowered, sufficiently resourced, and accountable for achieving sustained improvements in hospital and system-wide collaboration and performance on patient flow."

The Staib Sullivan Review, cited in the Auditor-General's Report, found that 'process barriers to improving [patient] flow included the lack [of] alignment between accountability for performance and the authority to act'. That is, although clinicians are accountable for performance, they do not feel authorised to facilitate system change. To see system change, there is still work to be done to clarify and embed roles, responsibilities and accountability at an individual and system level.

The Auditor-General's Report notes a perceived "absence of effective leadership within hospitals, THS and the wider health systems as the major impediments to tackling longstanding cultural barriers to change and the dysfunctional silo mentality...which [contribute] to bed block, ineffective discharge planning and bed management, and the ongoing lack of coordination between EDs, inpatient wards and the community". There are a number of improvement initiatives currently underway within the THS to improve hospital practices and patient flow. As noted by the Auditor-General, their effectiveness will depend on the ability of Tasmania's health system to overcome those governance and cultural challenges that have impeded effective implementation of past reforms.

Further the Auditor-General's Report noted the Government introduced significant reforms to the institutional arrangements for Tasmania's health system in 2018 to improve governance and the performance of the THS. These changes are in the early stages of implementation and cannot yet be reliably assessed.

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[25] J. Richardson et al, Tasmania's Health System: Reforms for the 21st Century, May 2004
[26] The Commission on Delivery of Health Services in Tasmania: Report to the Australian Government and Tasmanian Government Health Ministers, April 2014.

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Where to from here

We all must think carefully about the potential impact of our decisions and actions as they relate to our health system, be answerable for them, and operate within the agreed corporate mechanisms of accountability and decision making.

The THS is governed within an accountability framework that sets out expectations for strategic and operational day to day decision making across the health system, from the Minister to the clinical stream leaders and beyond. There is an expectation that all employees will perform in line with their statements of duties and performance management plans, be responsive to Government priorities, and deliver quality services.

Our executive and senior leaders, both administrative and clinical, will be critical to modelling responsible decision making across the THS. Clinical stream leaders must be equipped and supported to perform in their leadership roles and to provide high level strategic leadership to the services within their stream. They need to work in partnership with hospital leadership to achieve whole of facility and system objectives.

While the THS is still implementing key leadership accountabilities through the clinical stream model, this does not present a barrier to improving patient flow in the interim. Rather, being mid-implementation provides an opportunity to test, refine and enhance the current accountability framework, in order to test whether there is a clear understanding across all levels of our health system of what needs to be done, who is responsible for doing it, and by when. It also provides the opportunity to understand what administrative and regulatory support is needed and available to ensure leaders in the THS can adequately discharge their responsibilities.

Over time, we need to clarify and embed roles and responsibilities to ensure each individual in our health workforce is confident in their ability and authority to identify and resolve issues. Where these issues sit outside a person's delegated responsibility, staff will be supported and expected to escalate them up the organisation's structure appropriately.

Clear processes to monitor and manage performance across key roles in the health system must be in place so we can hold ourselves and each other to account to implement solutions that are hospital and system wide. Continuous service improvement requires that employees are empowered and authorised to make decisions but also accountable and responsible for financial and operational outcomes.

Ultimately, no matter where we work in the system, we have a shared responsibility for patient outcomes across the system, within our facilities, within and across our teams and as individuals. The decisions made locally at the clinical stream level can affect patient outcomes at a system level. This means that we must strive to find a balance between local decision making and working collaboratively to address the challenges faced at a facility and system level. Systems and processes for decision making need embedding and clarifying where issues cut across multiple clinical streams and therefore require collective accountability.

Royal Hobart Hospital

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Workforce Paper
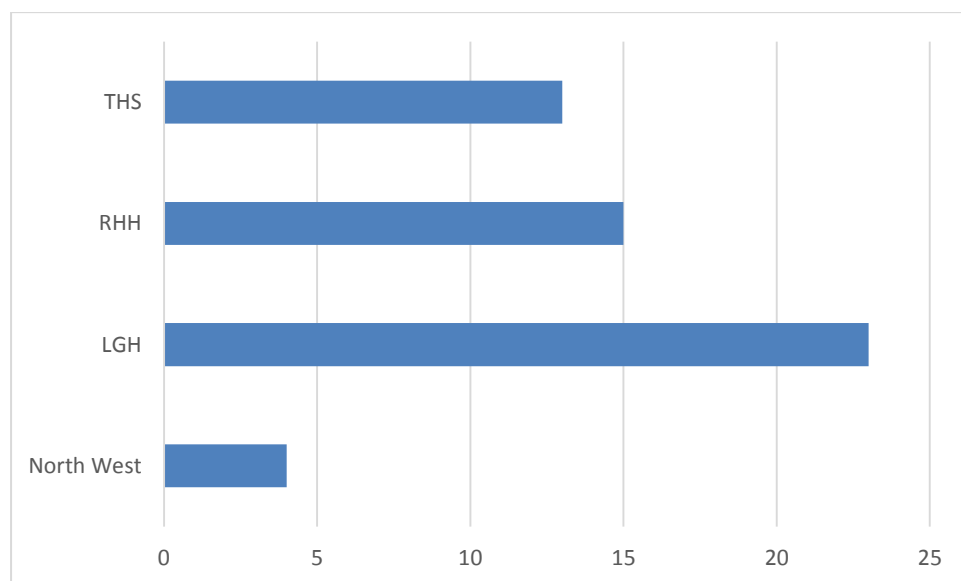
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Key Points

- The Royal Hobart Hospital (RHH) full time equivalent workforce has grown by 15 per cent over the last five years.

- The growth in the Emergency Department (ED) staff has been 34 per cent over the same period.

- In the ED, the FTE of Salaried Medical Practitioners have grown by 44 per cent with nursing staff growing at 39 per cent.

- Tasmania has a supply of registered emergency medicine specialists per head of population that is slightly higher than the national average.

THS Workforce

The Tasmanian Health Service (THS) had 9 087 FTE employees at 23 March 2019. This is a five-year increase of 13 per cent over the 8 062 FTE employees at pay period ending 29 March 2014.

In relation to the hospital workforces, the biggest growth was in the Launceston General Hospital (LGH) at 23 per cent followed by the Royal Hobart Hospital (RHH) at 15 per cent and the North West Hospitals (NWRH and MCH) at four per cent.

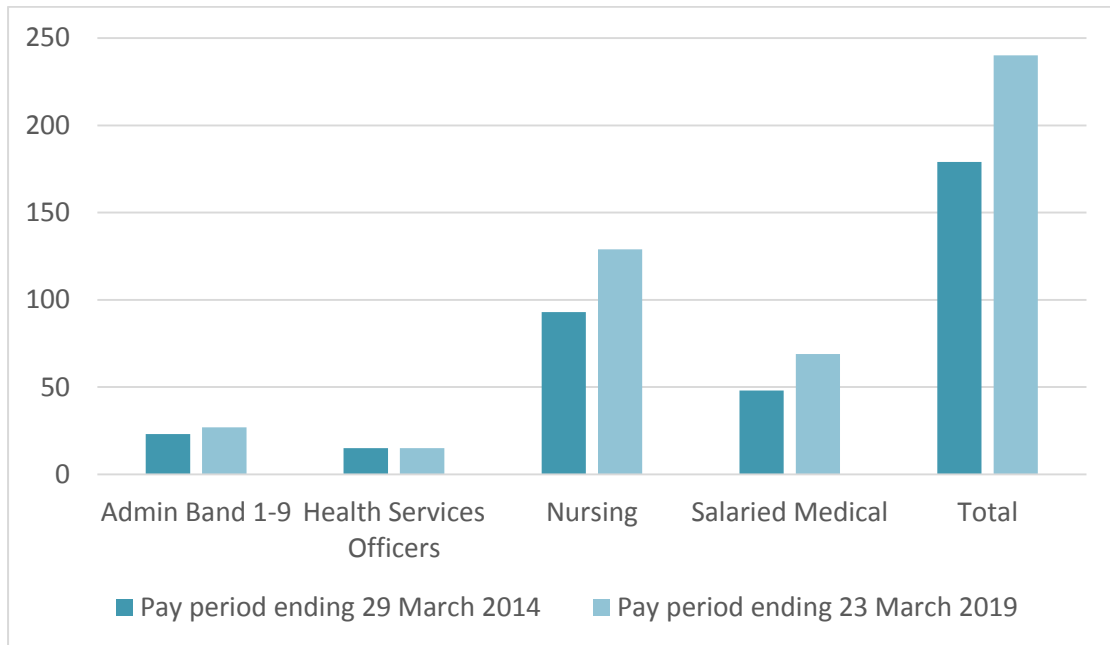Figure 1: THS hospital workforce growth 2014-2019 (FTE, %)

RHH Emergency Department- Workforce Trends

The Emergency Department was staffed by 240 FTE employees in 2019. This has grown by 34 per cent over five years. This is significantly greater than the overall growth rate for the RHH of 15 per cent.

Salaried medical practitioners (junior and senior doctors) and nursing staff had the highest growth rate over the five years at 44 per cent and 39 per cent respectively.

This results in these workforces representing increasing proportions of the overall ED workforce with the support staff decreasing in proportionate terms.

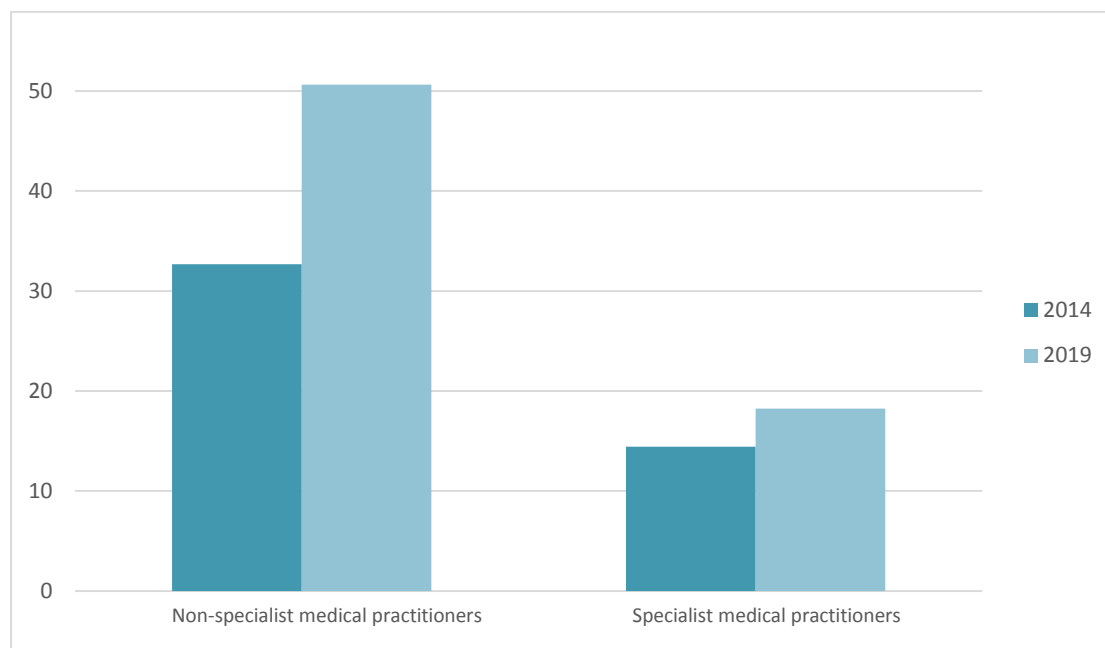Figure 2: RHH ED Staffing numbers by Award, 2014, 2019 (FTE)

Source: DoH FYI data

RHH Emergency Department- Medical Workforce Trends

The medical staffing in the RHH ED has grown by 44 per cent over the last five years. Within this, the growth in junior medical staff has been double the growth rate of the senior medical staff.

This disproportionate growth may have implications for supervision and training requirements by the specialist workforce who may need to divert more of their time to the supervision and training of junior doctors limiting capacity for direct patient care.

Figure 3: RHH ED Growth in Salaried Medical Practitioners 2014-2019 (FTE)

Source: DoH FYI data

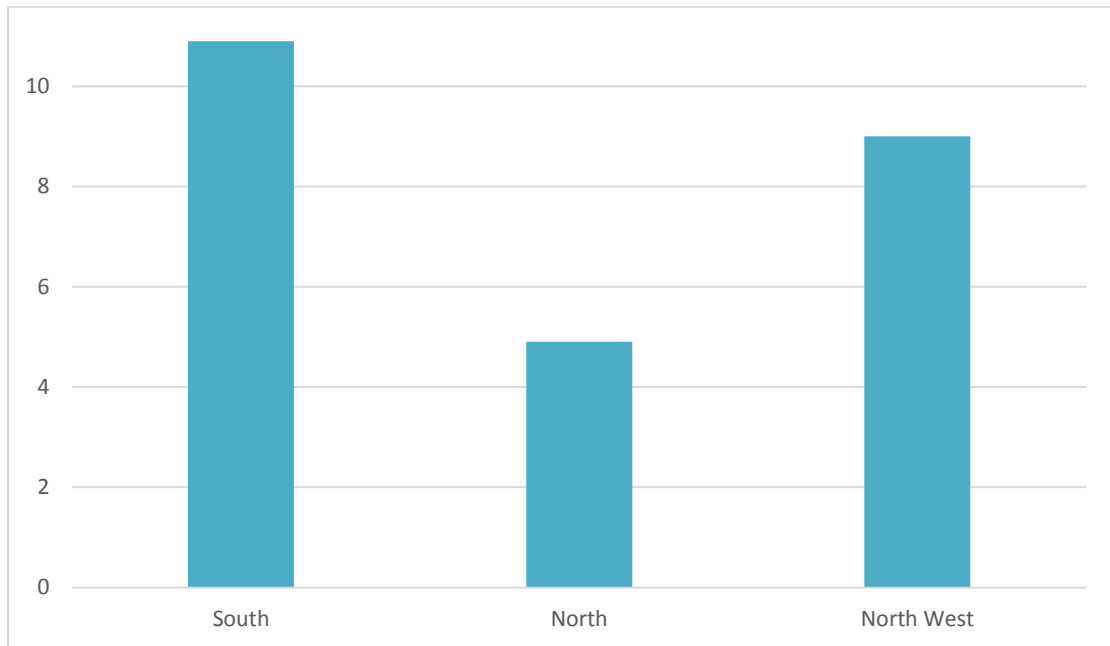## Emergency Medicine Specialists - Public and Private Sector

National registration data demonstrates that in 2017 Tasmania had 47 registered, employed emergency medicine specialists. In relation to supply, Tasmania has just above the national average at 9 employed emergency medicine specialists per 100 000 compared to 7.7 per 100 000 nationally. The workforce had grown by 39 per cent over the four years to 30 June 2017.

The density of clinicians to population was highest in the South and lowest in the North.

While the majority of clinicians are working in the public hospital emergency departments, there are a number, particularly in the South, working in other settings like Ambulance Tasmania and the hyperbaric unit.

The number of medical practitioners training to become emergency medicine physicians across Tasmania in 2017 was 41. This is a high number in relation to the existing specialty workforce and may indicate a future imbalance between the training output and the requirement for specialist emergency physicians.

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Figure 4: Employed Emergency Physicians per 100 000 population, 2017 (headcount)

Source: National Health Workforce Data Set including Tasmanian Unit Record Data (2017), ABS population data cat. 3235.0 (2016 and 2017).

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