23 March 2019

Mr Anthony Beasley

Secretary
Select Committee on Health Services in South Australia
Legislative Council
South Australia
Schealthservicesinsa.parliament.sa.gov.au

Dear Mr Beasley

Thank you for the opportunity to contribute to the Select Committee on Health Services in South Australia. The Australian Medical Association (SA) has attached feedback related to the first components of the Select Committee review, related to both EPAS (page 2-5) and Transforming Health (Page 6-10).

A separate submission will be provided in relation to other matters in detailed in sections c. and d. of the Select Committee Terms of Reference.

If you would like any further information or clarify any details in the submissions attached, we would be happy to discuss these with members of the committee at request.

We appreciate the work of the committee in leading this important work in South Australia.

Yours sincerely

A/Prof William Tam

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Contribution to the Select Committee on Health Services in South Australia

EPAS

Submission; The Australian Medical Association (South Australia)

The Australian Medical Association (South Australia) welcomes the opportunity to contribute to the Select Committee on Health Services in South Australian related to the subject of EPAS. The Association has consistently provided input to the EPAS process where invited and provided the views of our members both publically and privately when members have informed us of system issues or patient risk. The intention of EPAS was to improve access to timely information and to assist clinical practice improvement amongst a range of other goals. However, the resultant business case, procurement, implementation and adaption were best described as fragmented, reactive and not fit for purpose in the South Australian public health system.

The AMA (SA) recognises the importance of good IT systems to ensure information exchange and data management to support high-quality health care in a timely and responsible manner. The Association supports change in line with the principles of ethical medical practice, notably: patient safety, quality improvement, patient value and a strong public health component to ensure equality of access to high quality health care, training and research. Our members regularly informed us that the EPAS implementation, training and feedback related to quality were not supportive of these key principles.

South Australia's health system is considered inefficient when compared to other jurisdictions in Australia.[1] Yet, the one opportunity to improve efficiency and establish accessible information to inform decision making and patient care has been considered by the majority of our members as being in opposition to efficiency. The views on both OACIS and EPAS have been debated with the former being a clinical system with clinical input into implementation and trials in Renal units. The EPAS business case included the elimination of data entry by clerical staff which led to some of the factors related to implementation. Additionally, the EPAS product is regarded as clunky, inefficient, and the screen format and usability as inferior to OACIS. [2] The decision to select EPAS and combine clinical systems with patient administration has been highlighted as problematic by the Auditor General, and does not require repetition by the AMA.

The AMA was of the belief that the EPAS system would provide benefit for SA Health patients and staff in many ways, including:

- saving patients from having to constantly repeat their medical history and personal details
- providing improved patient safety when health-care professionals move between health-care facilities

[1] AMA Public Hospital Report Card, Australian Medical Association Public Hospital Report Card 2018, https://ama.com.au/system/tdf/documents/AMA%20Public%20Hospital%20Report%20Card%202018_0.pdf?file=1&type=node&id=48026 accessed 17 March 2019. SA Budget Papers 2018-19

[2] AMA SA – Personal Member Letter to the AMA President (2 August 2019)

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• improving clinical work practices across all SA public health-care facilities and supporting the provision of better integrated care, by allowing timely access to clinical information when and where it is needed
• providing the ability to view the patient's management across the health-care system, thus enhancing continuity of care, and making the medical record easily accessible at the time of treatment. [3] The extent to which any of these statements have been achieved remains unclear.

The AMA informed its members of the pending EPAS review in May 2018[4]. The AMA view being that any review should focus on making the system more usable and safe including consideration that:
• Proximity login cards are implemented to reduce the current long waits to log into the system, which create inefficiency and delays (at the recommendation of the Coroner)
• More terminals and improved placement and positioning of screens should be addressed
• Improved, ways to customise the display of information so that critical data is at doctors' and Nurses' fingertips, was important
• Better labelling of documents and improved search functions are recommended
• Collaboration between SA Health and AMA (SA)'s EPAS working group could assist to make the EPAS system more usable and, in particular, the prescribing system workable for clinicians
• Integration with existing IT systems used in health – including primary care access for GPs and private Specialists should be considered
• Dictation software should be investigated.

A range of the resultant member contributions to the May 2018 article are included for the committee as reference. These comments provide a way of understanding the issues using common language and not complicated IT terminology. Comments on file at the AMA from members include but are not limited to the following:

> *"If EPAS was a car it would be an Edsell or perhaps a Leyland P76- perhaps the latter- promising much but delivering little "(DR N)*
>
> *"I understand there is a view that EPAS has incurred significant investment of more than $400m and there is a responsibility for return on this investment. If is probably no accident that the introduction of EPAS has seen most hospital budgets blow out and although a multi-factorial issue, the impact on morale and working conditions has probably had a significant impact" (DR B)*
>
> *"EPAS is IT system that is simply not logical, for example reading a book you go from page to page for continuity. That's what used to happen with clinicians writing notes, physios and the team writing in patient records, everyone saw what was going on and what changed over time. With EPAS you move between chapters of a book and you waste time. In fact it's a risk especially for tracking changes to patient results and observations like fluid intake and output. It is simply not logical. The medicines and prescribing parts are probably the most useful after all the years but even they still have problems that need addressing" (DR S)*

The range of flaws related to the business case, tender and implementation of EPAS in SA were highlighted by the office of the Ombudsman in 2018 which reported:

> "While the Ombudsman did not consider that the department's practice in itself amounted to maladministration, his view was, however, that the cumulative procedural errors in relation to contract execution and the failure to disclose the contracts was particularly significant given the

[3] AMA SA – medicSA August 2013 p17
[4] AMA SA – medicSA May 2018 p13

scale and nature of the EPAS project and the public interest in its implementation. While the Ombudsman accepted that the department has taken steps to address those deficiencies, his final view was that the failure to observe proper procurement processes was wrong for the purposes of section 25(1) of the Ombudsman Act." [5]

At an operational level, the implementation can also be described as wrong. Without access to implementation plans, consultation that occurred, outcome measures and process measures for the implementation, it is difficult to understand if implementation was driven by a clear, measurable and organised planning and evaluation systems. Feedback from our members indicates strongly that there was an absence of training and education for hospital staff, a sign of limited engagement with the end users of the EPAS system.

Examples of good practice related to IT change and implementation can be found in a range of academic and IT journals. We aim to inform the Select Committee of the importance of focussing on best practice, fit for purpose, well scoped, well researched and supported implementation and evaluation of IT projects in SAH. The opportunities to learn from other sectors such as defence and from successful healthcare IT integration including Singapore and Canada should be pursued. Establishing projects that focus on clinical transformation engaging with users as opposed to the perception of an IT project will assist in supporting change. The former focussing on reducing harm and driving change for patient care benefits. A recent example in Australia is the work of the Royal Children's Hospital (RCH) Melbourne, where change was led in reference to international engagement models using the HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) [6]. This is one example only of many that could inform and improve the management of IT related change in our health system.

We provide a summary of recommendations to the committee for review.

Recommendations for Committee consideration

- The decision to amend and build on *Allscripts* as the re-badged SUNRISE software is provided with transparency to allow input from users of the system to consider and highlight operational, evaluation and process aspects of the proposed system and changes that will impact on clinical input and data.
- That any future technology "plug ins" or adaptions be considered in the context of innovation in the global environment of healthcare technology.
- That a process of engagement with users be established and implemented, aiming to test and trial new systems and considering the learnings in such trials.
- That Health system IT changes are supported by clear governance in reference to a SAH digital strategy linked to both State and National agendas and associated standards.
- That the interoperability of other systems including diagnostics, community care and telehealth as well as hand held monitoring be considered and included in a dynamic SAH digital strategy.
- That the SA Government invest in seeking worldwide advice on systems and opportunities in IT systems as opposed to reinvesting in technology that is not fit for purpose or considered best practice.
- That SAH engage with the AMA and other professional bodies via a reformed or new Clinical Advisory Council within SAH to advise and engage with Administrators and Planners of IT change

[5] www.ombudsman.sa.gov.au/.../Summary-of-final-report-in-relation-to-SA-Healths-EPAS-Procurement-Issues.pdf Accessed 23-3-19

[6] HIMMS Analytics Adoption maturity model www.himmsanalytics.org Accessed 20-3-19

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- That the Select Committee understand the inextricable link between procurement processes and the ability to provide best care for South Australians using a range of IT solutions in the future.
- That models of best practice for IT change be considered in planning and implementation phases , adapting and learning from the IT system reform in countries not limited to but including Singapore, Canada and those that manage change using the HIMMS adoptions model or an alternative adoption model that meets best practice in the health sector.

We thank you for the opportunity to contribute to this committee review and can provide more information at request.

Yours sincerely

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Contribution to the Select Committee on Health Services in South Australia

Transforming Health

Submission; The Australian Medical Association (South Australia)

The Australian Medical Association (South Australia) welcomes the opportunity to provide insights into the South Australian experience of health reform throughout the Transforming Health era of 2015-17. Over the past three years, the association has consistently provided the views of our members publicly and privately on the impact of the strategy on clinicians and patients. It remains the view of the majority of our members that the Transforming Health measures to centralise acute care services has diminished our capacity to provide quality health care for those who need it when they need it. Transforming Health's strategy to invest in acute care services in three metropolitan hospitals, the Royal Adelaide Hospital, Flinders and the Lyell McEwin, while downgrading acute care in favour of rehab and elective surgery at other key metropolitan hospitals has created long delays for treatment of some patients.

The AMA(SA) notes the need for continual transformation and evaluation of the health system to ensure that it is able to deliver the high-quality health care the public expects in an economically responsible way. The association has always supported transformational change in line with the principles of ethical medical practice, notably: patient safety, quality improvement, patient value and a strong public health component to ensure equality of access to high quality health care, training and research. Our members have consistently argued that South Australia should build on the strengths of its health system that have emerged organically in different hospitals, rather than imposing a centralised system to construct competitive advantage. State sponsored innovation, such as that in Japan has been shown to be less effective than spontaneous clusters such as Silicone Valley. [7]

The AMA's Public Hospital Report Card 2018 notes that health spending was 10% of Australia's GDP in 2015-16, which is stable and sustainable when compared with the 10-year average of 9.4 per cent.[8] Australia is below the OECD average and achieves better health outcomes for its significantly lower proportional spend than the USA (17%), and also spends proportionally less than many other countries including the Netherlands, Switzerland, Sweden, Germany and France (all around 11%)[9]. Yet South Australia's health system is not operating as efficiently as systems in most other states.[10]

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[7] K. Ready, Japan's Emerging Culture Of Innovation: The Invisible Things Can Be The Hardest To Change, Forbes Magazine, Nov 10, 2015 https://www.forbes.com/sites/kevinready/2015/11/10/japans-emerging-culture-of-innovation-the-invisible-things-can-be-the-hardest-to-change/#510e23144f4d accessed 16 March 2019

[8] Australian Institute of Health and Welfare, Health Expenditure Australia, 2015-16 Table 2. Cited in Australian Medical Association Public Hospital Report Card 2018,https://ama.com.au/system/tdf/documents/AMA%20Public%20Hospital%20Report%20Card%202018_0.pdf?file=1&type=node&id=48026 accessed 17 March 2019

[9] OECD Statistics, Health Expenditure and Financing http://stats.oecd.org/Index.aspx?DataSetCode=SHA# cited in Cited in Australian Medical Association Public Hospital Report Card 2018,

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A report on Australia's Healthcare System by PriceWaterhouse Coopers in 2016 also noted that Australia's healthcare system and its outcomes rank highly compared to other countries' health systems.[11] But while life expectancy is increasing[12], an older population will experience higher rates of chronic and degenerative diseases. The report noted the need for Australian policy makers to look for ways to enhance the contribution of the health care sector to the economy by attracting foreign investment and talent, especially in the R&D area. In this context, South Australia should be looking to export the healthcare services where we excel.[13] This will require clinicians, policy makers and patients to co-design a health system that seamlessly manages the patient journey regardless of funding structures and political and clinical jurisdictions.

Transforming Health was supposed to improve the quality of care to address 10 issues:

1. A higher hospital death rate than other states
2. Poor overnight access to senior clinicians
3. Insufficient opportunities for staff to maintain their skills
4. Too many cancelled elective surgeries
5. Low day surgery rates
6. Too many procedures performed
7. Long wait times for discharge or placement
8. Too many hospital transfers
9. The system performing below some national standards
10. Financial risks

Improving the quality of health outcomes was the stated aim yet it has since been established that its key objective was to save around $800-900m. However, health costs have continued to rise, up $315m in 2017. The Royal Adelaide Hospital also caused unplanned additional expenditure of $240m last year.

While the official evaluation of the program will not be released until June 2019, evidence from those who work in the system suggests that Transforming Health has not delivered against at least five of these objectives (3,7,8,9,10). An AMA(SA) survey of SA doctors and final year medical students in 2016 found 31.5% strongly disagreed that the Transforming Health initiatives would provide better care for patients and nearly 30 per cent disagreed with the statement. This sentiment has continued to be expressed throughout the life of the initiative and even now after it has ended.

Our members' concerns have been focused on five areas where Transforming Health has had a significant impact on the health system:

- Access to care
- Quality of clinical outcomes
- Impact on training

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https://ama.com.au/system/tdf/documents/AMA%20Public%20Hospital%20Report%20Card%202018_0.pdf?file=1&type=node&id=48026 accessed 17 March 2019.

[10] AMA Public Hospital Report Card, Australian Medical Association Public Hospital Report Card 2018, https://ama.com.au/system/tdf/documents/AMA%20Public%20Hospital%20Report%20Card%202018_0.pdf?file=1&type=node&id=48026 accessed 17 March 2019. SA Budget Papers 2018-19

[11] Bloomberg, "Most Efficient Health Care 2014: Countries". Accessed 16 March 2019

[12] By 2055, average life expectancy will be 95.1 years for men and 96.6 years for women. Australian Treasury, "2015 Intergenerational Report: Australia in 2055," 2015.

[13] C. Bartlett, S Butler, C Logan, Australia's Healthcare System: An Opportunity for Economic Growth, PWC, Sydney June 22 2016, https://www.strategyand.pwc.com/media/file/Australias-healthcare-system.pdf.

- Impact on research capability
- Impact on regional health care

Transforming Health resulted in a shortage of beds and access to appropriate care continues to be a problem with many patients waiting hours to be admitted to emergency departments. Downgrading of Modbury, Noarlunga and the Queen Elizabeth Hospitals, resulted in a loss of acute-care beds, including high dependency/ high observation facilities while the closure of the Repatriation Hospital removed a net 120 beds from the southern network. This means the system has been unable to meet the needs of an ageing population and, with poor access to step-down and home care facilities; the inability to release patients from hospital has caused well-documented bottlenecks and delays in admissions. Our health system has experienced a rise in ambulance ramping leading to a number of critical incidents outlined in the Hibbert Report into Systems Factors related to South Australian Ambulance Service (SAAS) Safety Incidents in 2018.[14] In addition, Professor Hibbert noted that in recent years the SAAS organisational focus has been mainly on achieving non-clinical targets or KPIs such as activity, response times, and throughput. The setting, focus and achieving of these targets has "taken the focus away from the patient" as clinical staff are aware of the need to achieve the KPIs.[15]

The AMA's Public Hospital Report Card 2018 shows South Australian hospital emergency department performance is at the lower end of the scale with 64% of patients staying four hours or less compared to 75% in NSW, 74% in WA and 71% in Victoria. The proportion of South Australian emergency patients being seen within the recommended time was also relatively low at 52% compared to 75% in NSW and 70% in Victoria.[16]

The loss of the Emergency Department, acute medical services, surgical beds, emergency surgery and major elective surgery at The Modbury Hospital has caused considerable hardship to patients in the North East of Adelaide despite additional services at the Lyell McEwin Hospital. The Modbury Hospital's 10% incidence of ambulance transfers is the highest in the country and clinicians note adverse patient outcomes associated with transferring patients when they are most unwell. The AMA(SA) noted in 2015 that "it is a high-risk strategy to remove acute and surgical inpatient beds at metropolitan hospitals and propose that patients requiring admission via ED be transferred to another facility".[17] Outsourced radiology has also caused problems with certain procedures only available on particularly days of the week – regardless of need.

The spine hospitals – the Royal Adelaide Hospital, the Lyell McEwin Hospital and Flinders Medical Centre – have not been able to meet demand for emergency services. The Royal Adelaide Hospital is yet to be fully utilised, partly due to the high cost of staffing private rooms.

In addition, the current practice of requiring doctors to negotiate with other doctors and trade beds throughout the system in order to make room for intensive care unit admissions is inefficient and

[14] Professor P Hibbert Final Report on Systems Factors related to SAAS Safety Incidents in 2018, file:///C:/Users/jford/Documents/AMASA/Transforming%20Health/Report%20on%20Ramping%202019.pdf, accessed 17 March 2019

[15] Professor P Hibbert Final Report on Systems Factors related to SAAS Safety Incidents in 2018, file:///C:/Users/jford/Documents/AMASA/Transforming%20Health/Report%20on%20Ramping%202019.pdf accessed 17 March 2019

[1616] AMA Public Hospital Report Card, Australian Medical Association Public Hospital Report Card 2018, https://ama.com.au/system/tdf/documents/AMA%20Public%20Hospital%20Report%20Card%202018_0.pdf?file=1&type=node&id=48026 accessed 17 March 2019.

[17] Transforming Health: the AMA(SA)'s response, 2015

results in long delays for acute care hospital admissions. Cases such as that of a patient with Guillain Barre syndrome who experienced respiratory failure at the Modbury Hospital and waited six hours before being transferred to the Lyell McEwin Hospital due to lengthy Round Robin negotiations between doctors over beds are common.

Doctors have reported particular hardship for elderly patients who have been transferred numerous times before being admitted, often long distances from their family support networks. The AMA(SA) has also pointed to an increase in the readmission or churn rate associated with early discharge without appropriate step-down care.

The Central Area Health Network has recently attempted to overcome the bed shortage at the RAH and at the QEH by outsourcing 800 public patients on long-term elective surgery waiting lists in metropolitan private hospitals. In addition, all public joint replacements in the south are performed at private hospitals. This system does not address the root causes of the bed-shortage, particularly in acute care.

Pressure on services and fatigue has created an unpleasant culture in the RAH in particular, prompting medical and nursing staff from the emergency department, critical care and mental health to leave. South Australia's appeal as a training centre has also been diminished by the well-documented decline in morale throughout the system.

The loss of clinical case mix through the downgrading of acute services at non-spine hospitals resulted in reduced training places and research capacity. While cardiology services at the Queen Elizabeth Hospital were reinstated, there has nonetheless been a loss of some clinicians interstate. In its response to the Transforming Health initiative in 2015, the AMA(SA) noted that reducing the types of clinical services provided by each hospital will lead to patient services being fragmented between more than one site. The AMA(SA) noted: "Providing routine ophthalmology services at Modbury Hospital and complex eye surgery and trauma at the RAH will lead to fragmentation of eye treatment and training for future ophthalmologists." This has been the experience in a range of specialties.

The AMA(SA) has also argued that over-investment in metropolitan "super hospitals" at the expense of regional hospitals and the centralisation of control of resources is inequitable and inefficient. The association welcomed the announcement of investment in Local Health Network Governing Boards, $140m for capital works in country hospitals and additional funding for regional staff to ensure better treatment for country patients near their homes.[18] The Australian Institute of Health and Welfare's Report on Australians' Health 2018 finds rural and remote Australians experience higher age-adjusted death rates, which increase with greater remoteness. People in *Very remote* areas have a death rate nearly one and a half times as high as people in *Major cities* (759 per 100,000 population compared with 524 per 100,000). Potentially avoidable deaths are deaths among people aged under 75 that may have been preventable through health care. The rate of potentially avoidable deaths also increases with remoteness.[19] It is thus vital to prioritise regional health care, including preventative medicine.

Recommendations for Committee consideration

The current government has undertaken to re-instate acute care services at the Modbury, Queen Elizabeth Hospital, Noarlunga Hospital and the Queen Elizabeth Hospital and to re-open the Repat Hospital. Yet a year later, the community is still waiting for these revisions to occur and bed shortages

[18] State Budget 2018-19 Paper No. 1, p 11.

[19] https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/all-is-not-equal accessed 16 March 2019

and ambulance ramping continue. The proposed measures should be implemented as soon as possible. The AMA(SA) has consistently argued that without addressing bed block issues including inpatient and step-down facilities, there is no capacity in the system for more efficient patient flows. To address the poor patient experience associated with the Transforming Health centralisation initiatives, the association recommends:

- Reinstatement of acute care and high observation facilities supported by appropriately skilled staff in medical and surgical wards at metropolitan hospitals.
- Co-design[20] to review patient flows and the round robin negotiations that currently characterise hospital admissions
- Well-funded, best practice step-down institutions with appropriate GP liaison
- Co-design to review clinical inefficiencies at the RAH and investment in appropriate staffing levels to ensure that the hospital can operate effectively at capacity.
- Co-design to prioritise training and research throughout the system. Reinstating acute services at metro hospitals and expanding the case mix for specialists should help to increase opportunities for training and research
- Investment in regional health services and greater locum support to encourage doctors to work in country areas
- More access to acute mental health services
- More access to palliative care services.

Thank you for the opportunity to contribute to this important review. We would be pleased to provide more information if it is required.

Yours sincerely

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[20] See for example KPMG's Design Thinking methodology or the Victorian Government's Strong Families, Safe Children Co-design 2016 https://www.strongfamiliessafechildren.vic.gov.au/moving-to-co-design accessed 16 March 2019.

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