THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE, GOVERNMENT ADMINISTRATION A SUB-COMMITTEE INQUIRY INTO RURAL HEALTH SERVICES IN TASMANIA MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE ON TUESDAY 30 NOVEMBER 2021.

Ms ELLA van TIENAN, STATE MANAGER, **Dr SHANE JACKSON**, PHARMACEUTICAL SOCIETY OF AUSTRALIA WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you for your submission and to provide further detail regarding that. This is a public hearing. All the information you give will form part of our public record transcribed by Hansard and published on our website and inform our report at a later time.

What you say here is covered by parliamentary privilege but if you want to say something outside that may not be the case. If there was anything of a confidential nature that you wanted to discuss with the committee you could make that request and the committee will consider it. Do you have any questions before we start?

Dr JACKSON - No.

CHAIR - Would you like to speak further to your submission and members will have questions.

Dr JACKSON - My name is Shane Jackson. I am a pharmacist of over 20 years' experience. I graduated from the University of Tasmania in 1998 and completed a PhD in 2004 and have operated a couple of rural pharmacies in Tasmania - one since 2004 at Nubeena on the Tasman Peninsula and the second at South Arm on the east coast of Tasmania since about 2010.

Since the early 2000s I have also travelled to remote areas of the state, Queenstown, north-west coast, north-east coast, almost everywhere to do medication reviews for aged care residents across the state. I am pretty familiar with a lot of the challenges that are evident in rural Tasmania. I will pass over to Ella for an introduction before I go on.

Ms van TIENAN - My name is Ella van Tienan. I am also a pharmacist. I am a bit younger than Shane, I graduated in 2005 and I grew up on the Tasman Peninsula. I am from a rural area and I have worked for Shane in some of his rural pharmacies. I did my internship in some rural areas as well in the north and central-north and now I am the state manager for the Pharmaceutical Society and so I represent the Tasmanian pharmacist community.

Dr JACKSON - Chair, you will have received and probably at late notice, my apologies, the documents that were sent through yesterday to committee members. I have copies if necessary.

CHAIR - Did they come through here or not?

Dr JACKSON - I have copies.

CHAIR - If you could provide those.

Dr JACKSON - Many of you would have received visits from us during World Pharmacist Day to talk about a lot of the work that has been performed by pharmacists across the country and especially in Tasmania over the last few years but also during COVID-19 times. I wanted to run through some brief statistics but also to highlight things about the pharmacist workforce and the opportunities, and I will take the opportunity to answer any questions that you might have from a pharmacist perspective in rural Tasmania.

We have gone to some recommendations first and I will briefly outline those. The first is to have some accurate workforce data around pharmacists in Tasmania across rural areas. It is largely anecdotal. The granularity is not at the level that we would desire. The statistical area data does not give us the granularity around whether there is a pharmacist at Dover, whether there are pharmacists needed in Swansea, St Helens, north-west coast. The first thing is that we need to have some accurate data around where pharmacists are located, their capabilities and their capacity so that we know what they can do moving forward.

CHAIR - Whose job is that, Shane? Who do you think should do that?

Dr JACKSON - That should be departmental. We have a health workforce strategy 2040 which has allied health as part of that and allied health includes pharmacy. We have extrapolations that when you look at those indicates that we have a significant allied health workforce shortage across the state, as in we are not reaching the targets of workforce growth that is projected. If you look across those numbers, the allied health needs are increasing in the low 20 per cent mark and pharmacies are increasing at 14 per cent, for example. That difference is going to be magnified as we go forward year on year.

Dr SEIDEL - You are referring to dispensing pharmacists, I imagine, when you talk about workforce and, in particular, in rural areas?

Dr JACKSON - I am referring to pharmacists in general, FTE pharmacists, and then from a granularity point of view we need to identify the community pharmacists from a medication provision point of view.

Dr SEIDEL - Isn't that a challenge because you have the Pharmacy Guild which is sort of responsible for ensuring that there are pharmacies and pharmacists in every area and I think that there is a contract in play with the federal government. You would consider, because of that contract, that the Guild should be taking care of it. The flipside would be the State Government would say 'it is not my responsibility to ensure that there are pharmacists in Nubeena now', and the data should be generated in terms of workforce provision in those areas. They should probably be coming from the Guild as part of their contract. Is that not happening?

Dr JACKSON - That is a good question, Bastian. A pharmacy as a site, an infrastructure distribution point of view, yes, the Guild as part of their community pharmacy agreement negotiations with the government has implemented the location rules which says this is where pharmacies can be.

Largely from a rural perspective, if we wanted to open a pharmacy at Dunalley or at Forcett or anywhere like that, or in most places on the north-west coast or anywhere else, you would be able to get a licence to do that but the viability would be of question. You would not have the population to do that.

So they govern that but they do not govern the scope of practice in the context of what is done in those sites. A lot of the scope of practice is actually state government Department of Health legislative driven. The conduct, what we do, is governed by the state; where we are located is governed by the Commonwealth from a financial remuneration point of view.

Dr SEIDEL - Again, it is the Commonwealth that is responsible for ensuring that there is a dispensing pharmacist in each and every rural area of Tasmania. There is nothing the state government can say. There is no area of district workforce shortage for pharmacists for example.

Dr JACKSON - The Commonwealth is primarily responsible, as you know, for the distribution working groups which decide on financial incentives to encourage people to go to rural areas. Pharmacists are unfortunately not as included in those areas as what they could be. You are right, the Commonwealth has responsibility for trying to get people to go to those areas.

Dr SEIDEL - To give you an example, if I may, because we had a situation in the Ouse area where there was, we have heard in media reports, a pharmacist who was no longer able to be in that area. Therefore, there was significant angst in the community where medicines would be coming from. Is that, again, a Commonwealth responsibility to ensure a pharmacist is there? If somebody has to retire or feels they cannot continue because of whatever regulation has been put in place for them, who is responsible to ensure that people have access to medicines dispensed in local pharmacies?

Dr JACKSON - That is a good question. It is primarily the Commonwealth's responsibility in the context of financial actions they can take to support rural pharmacies. As we know in Tasmania some of those population areas are perhaps lower than what can support a pharmacy despite the financial remuneration from the Commonwealth. As in they are just too small to support a community pharmacy with the Commonwealth reimbursement that is in place.

We have seen instances where we might say General Practice is the same. We have seen instances and we hear instances of where the state government provides financial support to General Practices in variety of ways to service the local community. I would say that is a blended model to support health care provision including medicines provision.

Dr SEIDEL - There is the rural medical practitioners agreement in place which has been for decades. There is no equivalent for pharmacists.

Dr JACKSON - Can you restate that?

Dr SEIDEL - The equivalent of a rural medical practitioner's agreement where GPs provide services in district hospitals.

Dr JACKSON - Yes, that is a very good question. From an anecdotal point of view and I use my example here at Nubeena, we have an agreement with the entity down there which has a number of rural health beds but it is largely for the aged care residents. When I have reached out proactively to have an agreement around the delivery of services for those rural health residents and patients, it has largely been met with 'we can do that from our central hub'. Which actually does not support the infrastructure that is located locally.

CHAIR - So they are looking at things in silos. Is this what you are saying?

Dr JACKSON - That example, and that is replicated across the state, whereby the local pharmacist could be seen as extensions of the central hub located in Hobart, Launceston, north-west, but they're are not being as engaged in the service delivery in those regional small hospitals as they could be.

Mr GAFFNEY - So, just help me here. In the material we received from the PSA, they talk about community pharmacy agreements. Are they referring to federal agreements?

Dr JACKSON - That is the Commonwealth.

Mr GAFFNEY - So, it is just the Commonwealth agreement in that one. Thank you for clearing that up. Surely the information that you are trying to get is not that difficult, I would have thought? Is there a role for the Local Government Association of Tasmania in this to access that information about pharmacies and pharmacists? Or should it be the Guild that is doing that? Should that be a responsibility or is it a better way of doing it, an easier way?

Dr JACKSON - Given that pharmacy is part of the primary healthcare workforce, like occupational therapists, speech pathologist, podiatrists, we are no different to those groups that perhaps don't have as influential representative bodies of the principals, the owners. I wouldn't say that we would be expecting them to do that and if we are saying that we should be collecting data across the allied health workforce and working out where the gaps are, because the gaps in 10 years' time might not be in pharmacy, it might be speech pathologists, it might be podiatry, and we need to look at that holistically.

I think it should be departmentally collected and built upon, so that we can then work with groups like the University of Tasmania, secondary schools, to say, okay, where can we encourage our students to go to, so that we can support our workforce, because we can see what is happening in five or 10 years' time. It needs to be a coordinated approach.

Mr GAFFNEY - That is fine. Especially in light of what might happen in local councils too. It is 29 at the moment; it could be different, so it is going to change. When I looked at one of the tables there, it talks about Devonport or the West Coast. The West Coast is such a large area. Does that mean there is one in Queenstown and one in Zeehan, or there is not? Do you know what I mean? So, from that point of view, some of the information you get back is not that helpful because it is not specific enough.

Dr JACKSON - That is correct and it is also about the capacity and the capability within those sites. If we could attract another pharmacist, and there was remuneration in place for additional services, I could have another pharmacist or another two pharmacists at my pharmacy in Nubeena. We could be providing mental health support, we can provide chronic disease management, we can work more closely with our general practice colleagues, we can work more closely with the small hospital that is down there. But there is not that financial reimbursement to be able to do that and, to be frank, there is not the scope of practice allowance for us to do that.

Dr SEIDEL - I will stick with the workforce a bit longer. We know that we have real-time data on workforce when it comes to GPs in particular. We know exactly where they

are, what they do every day, it is real-time stuff. For dispensing pharmacists, I imagine that is the same, because I would know who is dispensing when and potentially what as well, because there is always the identifier that goes to Medicare. It will not cover other services that are not related to dispensing. As you said, mental health support, and I imagine other services as well, just having preventative conversations, for example. How much work do you do in rural pharmacies that is not related to dispensing work? For us to get an idea of what you actually do on a normal day?

Dr JACKSON - That is a really good question, Bastian. The other thing to note is that I have talked in other forums to the Commonwealth about collecting data at a granular level, at the pharmacist level. They collect data at that entity level. So, just as you said, perhaps, that data is being collected. That data is not being collected.

Ms van TIENAN - The pharmacy I work in has dispensed 300 scripts in a day, but you cannot see whether that has been done by me or me and three colleagues.

Dr SEIDEL - You are kidding.

Dr JACKSON - I am not kidding you.

Ms van TIENAN - Because the pharmacy claims the money, so that is where the data lies.

CHAIR - So, there is no data related, so the pharmacy in Wynyard, how many pharmacists are actually in there?

Dr JACKSON - Correct.

Ms van TIENAN - That pharmacy could be serviced by a single practitioner who is worked to absolute death, or it could have a massive workforce and they are all having a lovely time being able to have wonderful conversations at the same time. You cannot see that without actually going to the pharmacy and asking.

Dr SEIDEL - So there is no way of identifying who dispensed?

Ms van TIENAN - No, unless you go back into the pharmacy and look in the individual pharmacy records as to who dispensed each medicine.

Dr SEIDEL - But this again is only for the individual pharmacy. There could be different systems in place that is pharmacy specific?

Dr JACKSON - The payment mechanism through the community pharmacy agreements and through Services Australia is at the entity level and has no link between the individual practitioner. Therefore, we do not have the data around a workload, for example, at those levels. That has consequences in the context of workforce burnout and other things. Again, it is something that both I and the PSA raised at the Commonwealth level as a matter of priority.

Dr SEIDEL - So, in other words, we really do not know what the workload is? There is no auditing - for example, in general practice if you see more than 80 patients all of the sudden you get a phone call. That is not necessarily that you over service, because you know, 'you

must be very busy, what is actually happening here, can we help you in any other ways?' That does not happen, for community pharmacists, because there is no monitoring system in place?

Dr JACKSON - We do not have the data at the individual practitioner level.

Dr SEIDEL - So, you burn out, nobody notices.

Dr JACKSON - Correct.

Ms van TIENAN - I think the statistics that were in the workforce strategy that came from the government, the issue with those, was that it looks like, for example, southern Tasmania is well serviced by pharmacists, but the majority of them were actually in the hospital and the metropolitan area. Fred down at Dover does not have anybody to support him, and so, he says, 'well it looks like I am in an area that is well serviced by pharmacists, but actually I am here by myself, and my mate in Geeveston is by himself'. There is no data as to what the distribution throughout the state is. If you just look at that report, it looks like -

CHAIR - By pharmacist, not pharmacy.

Ms van TIENAN - Yes, it looks like there are enough pharmacies, and it looks like, in that data, we have enough pharmacists in the south, but actually the spread of them is not sufficient to cover the workload.

CHAIR - Is locum use monitored? Obviously, if you are a single pharmacist and you get sick or want to take a break, is that monitored? Do we know how many locums are used?

Ms van TIENAN - We don't know. Anecdotally, there are not enough at the moment, and COVID-19 has made that worse because we can't get them into the state. Anecdotally, there are shortages of pharmacists everywhere at the moment.

Dr JACKSON - And people are concerned. The owners of the entities are concerned about booking holidays because they are worried that they might get knocked out. If they travel, they worry that the person is coming in to replace them, so they are just working. They are just waiting to get some bandwidth in the future.

CHAIR - We just had a pharmacist die in Strahan, the only pharmacist.

Dr JACKSON - Yes, correct. Bastian asked what proportion of time is spent on dispensing and other activities. I will use my personal example at Nubeena. We've got about 1.8 FTE down there. So, about one FTE is allocated to the pharmacy operations, and 0.8 is allocated to outreach activities. That is work at the nursing home, home medication reviews, and what I would call other activities we might do at the local school, et cetera, as part of our contribution to the community. We are very lucky in that area that we have two very proactive pharmacists who are accredited to do medication reviews and we are able to do that.

In the context of the pharmacist's time, that one FTE that is based in the pharmacy, for example, you would expect that about 0.6 to 0.7 would be spent on dispensing operations and about 0.3 or so on other operations. Vaccinations for example, and other mental health support, which is quite predominant at the moment, and something I have been supporting my

pharmacists to deal with, because people just want to come in and see somebody and talk to somebody.

CHAIR - Can you outline the work a pharmacist is required to do? They may have nurse immunisers working in the pharmacy, but let's talk about the pharmacist and the work that's involved in providing the COVID-19 vaccine, the flu vaccine, whatever vaccine it is, to the patient who comes in to get them, and thankfully they do. How is that funded?

Dr JACKSON - At the moment with the COVID-19 vaccine, pharmacists are similarly trained, like nurse immunisers and others, to be able to administer COVID-19 vaccinations.

Ella might be able to remind me on the numbers of pharmacist vaccinators we have. It's remunerated by the Commonwealth. The remuneration for a vaccine by the Commonwealth is $16. In comparison, for general practice, as I understand it, it is a little more than $27 for each vaccine as well as a consultation with a GP to explain the benefits for a first and second vaccine. That probably amounts to about $100 across the COVID-19 vaccine and pharmacists get about $16 for a first.

CHAIR - Even though they also have to do the same pros and cons, benefits and risks?

Dr JACKSON - Yes, they do the same; $16 for a first dose, $26 for a second dose so that is about $42. From a proportionality point of view, it is a real struggle.

Certainly, that it is happening in my practice. I have another pharmacy in suburban Hobart, in Lindisfarne. We have vaccinated five GPs in the last week who have come into our pharmacy. They said to me, 'We don't know whether we are going to be doing boosters. We will look at that in January or February'. There is going to be a real impact.

CHAIR - Are these booster shots you were giving them?

Dr JACKSON - Yes, we were giving them they were booster shots. That will be a real challenge, not only for pharmacy across Tasmania but even more of a challenge for pharmacies in rural areas because of the financial reimbursement. It takes time.

Most of you would have had COVID-19 vaccine shots. It is not a simple process in the context of the consent form; just explaining to people and giving people time. Certainly, at the moment, for first and second doses that have been done this late in the vaccine rollout, people are reluctant. You don't want to rush them.

You need to have the reimbursement that gives you the time. It is not about pharmacists making money, I can tell you. It is about actually having the time.

CHAIR - I have had members of the community say that though.

Dr JACKSON - Absolutely. From a comparison point of view, one of my major concerns into early next year is the capacity of the community pharmacy workforce, especially in rural Tasmania to be able to pick up the slack from the Health department with their wind-down in their clinics but also general practice not being as prominent in the rollout as they were. General practice did a phenomenal amount of vaccines but they are a bit burnt out.

I suspect that some of them will pull back a little and so it will be pharmacy that is probably relied upon to do that.

Mr GAFFNEY - To follow up on that because I may not have picked up on the inuendo. When you said that the pharmacist said that they do not know if they will pick that up, is that because of their own choosing, or they haven't had a discussion with the federal government? Is it through their choice or because nothing is in train? Expand on that reason a bit further for me.

Dr JACKSON - The Commonwealth sets the remuneration. There is no role for state government in setting the remuneration though it may well need to consider if there is supplementation and support that may need to rolled out for general practice and other sites in the future, if there are barriers in regards to the uptake. Organisations like the Pharmacy Guild, Pharmaceutical Society, have been knocking on the door of the Health minister and everywhere around saying that the remuneration is inadequate.

I don't know whether pharmacies will take it up is in the context of the financial remunerations. It is a challenge for a pharmacy owner to query whether it is worth their while to allocate an additional resource or to put that job onto an existing resource which they know is already stretched. They have to make that decision around it being worthwhile in the context of what they can do on top of already normal business of ensuring somebody gets their medications and takes them safely. Can they do this as well?

Dr SEIDEL - It is a tricky one. On the one hand, you said the workload is already high. On the other hand, you are employed for being allowed to work full capacity and fullness of your practice.

Before exploring that, I want to go back to the COVID vaccination rollout, not to talk about COVID but to talk about essential services that need to be delivered in regional areas. I would like to understand what the channels of communications are. What I am hearing from you, is that you don't get much feedback from the Department of Health, Commonwealth or state when it comes to who is providing an essential service, this year the COVID vaccination. The job needs to be done. It is completely unclear who is doing this in a few months' time; whether it is GPs, pharmacists working together. And who is funding it? It is not clear whether the THS is funding this or the Commonwealth department or privately funded.

Do you have other channels of communications open? Do you have ready access to engage with the state and Commonwealth governments to ensure that people in Strahan can get their booster vaccination or people on King Island can get it? The person doesn't care who gives them the vaccine. They just want to make sure it is accessible and available.

Dr JACKSON - I wouldn't want my comments to be interpreted that there hasn't been a high level of engagement with the Department of Health here locally. Through organisations and also at the minister's level, the engagement has been excellent in the context of organisations. Then that has flowed down through to members and to practitioners on the ground.

That doesn't mean that things have moved quickly, and that communication on the ground has been exemplary. There have been opportunities to improve. For example, there has been rapid changes in the context of restrictions around pharmacists' administration of

immunisations. I will give you an example. If I wanted to vaccinate the residents at the nursing home at Nubeena, I would need the GP's consent to do that. If those residents come up to my pharmacy, they give me the consent. So, there are some barriers in place. The department in their wisdom have decided that is what they want from an engagement point of view but for every GP I have engaged with, they have gone, go ahead, go ahead.

CHAIR - What department has to give the permission, state or Commonwealth?

Dr JACKSON - The department here has said we need that. It is just an extra administrative layer on top of already administrative layers. The communication has been good but we have not agreed with some of the decisions. For example, some of the timeliness around engaging pharmacy in the booster rollout hasn't been as good as it could have been but they are decisions from the past.

Dr SEIDEL - Could it be that all the GPs who are working in Nubeena have to be credentialled through the THS? Is there a credentialling system in place for you as a pharmacist?

Dr JACKSON - There is a credentialling system in the context of being an authorised immuniser.

Dr SEIDEL - But not that you are allowed to provide a health service in a THS facility?

Dr JACKSON - I don't believe so.

Dr SEIDEL - That is why the GPs give permission to delegate.

Dr JACKSON - But it is all aged care.

Dr SEIDEL - So, it is for all of aged care, all Commonwealth facilities as well, so it is not only the THS acute staff?

Dr JACKSON - Correct. There is administrative burden and layers that have been put in place that are barriers. With the booster rollout, what will happen on the ground is that I and other pharmacists will say to the GPs, 'What are you doing?' Pharmacists will then say, 'This is what I need to do to pick up the slack', if they can. There are often local activities that are done, but the department is over here. Locally, they will work together but the two probably won't meet, unfortunately.

CHAIR - That could be compounded if we find that, like the UK, they bring forward the boosters?

Dr JACKSON - That is correct.

Ms LOVELL - In your submission, in the second dot point of the recommendations of what needs to happen for pharmacy, you said: 'Encourage pharmacists to work in collaborative healthcare teams in rural and remote areas.' Seems like a bit of a no brainer. What are some of the barriers that are in the way of that happening at the moment?

Dr JACKSON - I bring this down to two aspects, one being scope of practice. You've heard me talk about scope of practice before. Scope of practice is really important. It's really important from a workforce retention point of view because pharmacists feel like they're largely working with handcuffs on. Every issue that might pop up that is well within their scope of practice to fix, we need to call somebody else for authorisation. If that's not something that takes the wind out of somebody's sails, from a professional practice point of view, adds this administrative layer and takes you away from your clinical aspect, I don't know what is. So it's scope of practice and that is an absolutely locally based opportunity to take the shackles off.

Ms LOVELL - That's legislated?

Dr JACKSON - That's legislated. Then it comes down to financial. It's organisations like Primary Health Tasmania, for example, and the local Health departments around, 'well, what can we get pharmacists to do?' Like, for example, 'how can we get them to work more closely with GPs?', 'how can we get them more involved in, for example, extension of prescriptions, monitoring of people's cardiovascular disease when it comes to blood pressure and seeing whether that person needs to go back to their GP', et cetera.

One of the good things that the Health department has done only recently is provide some grants for pharmacies to open after hours. My pharmacy at Nubeena can now open Saturdays. We haven't been open Saturdays for a long time. It's something the community has wanted and we've been able to do that. That's a great step in a positive direction. We can link up with GP Assist in regards to people coming in, Telehealth because the broadband isn't great down there, or people don't have the ability to be able to call in. We are a site people can utilise. There are some steps in the right direction.

So, the first thing being scope of practice and the second thing being, 'let's identify what the issues are and can we financially support not only just community pharmacies but the primary healthcare infrastructure in that area', which might involve general practice as well and might involve others.

Ms LOVELL - In your experience and the experience of your colleagues that you're aware of, if those barriers were removed, are other primary care providers and allied health professionals in communities supportive of that type of collaborative relationship? Is that something other healthcare professionals would support, do you think, in those communities?

Dr JACKSON - Even more in rural areas. Rural people seem to be more pragmatic, no disrespect to anybody who is not in rural Tasmania, and more practically focused. They recognise expertise where it lies and want to solve the problem, not be focused on who's solving the problem. Absolutely, they want people to do more and to help more and to be more professionally satisfied and rewarded.

CHAIR - Shane, I know we're getting close to the end of time and we'll certainly read through what you've sent us. You've talked about all these things but I want you to try to put it in a succinct form for me: What would be your top three priorities in terms of the barriers that need to be removed, and how you remove those, then the top three things that would be needed to address the future workforce needs?

Dr JACKSON - From a barriers point of view, as I have said to many of you before, both Labor and Liberal parties at the lead-up to the last election committed to the scope of

practice review. We've been informed that that will commence in 2022 and finish in 2023. In my view, and in the view of the PSA, that's too long. We have been able to move on things during COVID-19 times much quicker and it's imperative that we move on that scope of practice review. The scope of practice review helps us break down those barriers in a coordinated way. So, the scope of practice review and the timeliness of that is the first thing.

CHAIR - Second thing? We'll come back to some of these if you want, but the second thing, in terms of barriers?

Dr JACKSON - The second thing is legislation. It's doing a comprehensive assessment of the legislation in the context of what is overly restricting pharmacists' practice, in the first instance, in a short-term manner. And the second being a long-term assessment that supports the scope of practice discussion. Then there is identification of activities that pharmacists can do in rural Tasmania based on need.

CHAIR - Locally based solutions.

Dr JACKSON - Yes, locally based solutions and the requirements to support that, mostly financial and capacity, capability training.

CHAIR - Why don't we just go to the workforce matters. Some of those cross over, obviously.

Dr JACKSON - Yes, they do. Workforce is granular data. When I mean granular data, it comes to capacity. What do we have and what is the capability? If we want booster shots in Swansea, are those pharmacists authorised immunisers and if they're not, how can we get them to be authorised immunisers? That is the granular data. What do we have and what is the capability?

Secondly, from a workforce point of view, a long-term look at the pharmacist workforce that supports the scope of practice review. If we are talking about pharmacists doing more, then we will need more capability, we will need more people. That needs to be considered in the context of the University of Tasmania's changes in the College of Health and Medicine and their allied health courses. That is going to put some real pressure on pharmacy enrolments.

CHAIR - When we call in UTAS to have a chat about this, what should we ask UTAS?

Dr JACKSON - How they will preserve and support existing courses in the allied health space, and enrolments, when they are expanding physiotherapy, podiatry, speech pathology and, probably, OT in the future. I am not saying that is a bad thing. We need those people. But those people perhaps would have gone to pharmacy in the past. If those people aren't going to pharmacy, where are the people who will go to pharmacy?

CHAIR - The third thing for workforce? We have granular data, more capability in terms of your scope of practice.

Dr JACKSON - And training to support the scope of practice review.

CHAIR - On the scope of practice review, it seems like a year is a long time to undertake such a body of work when things are changing all the time and we have seen how quickly we

can respond and have responded. What is a reasonable time frame? What would you tell the minister, if I was the minister?

Dr JACKSON - It should commence very early next year, in the first quarter of next year, and can be completed by the end of next year.

Dr SEIDEL - Most of the work has been done already, hasn't it?

Dr JACKSON - There have been that many reviews into the future of the pharmacy profession. We just need to say 'okay, what do we want our pharmacists to do in Tasmania and how do we get them to do that?'.

Dr SEIDEL - Just to be clear, the body of the work has already been done, it requires political will to actually get going, right? It is a pathway, step 1, 2, 3, but the timelines can be tight.

Ms van TIENAN - We will save so much effort to stop us coming and going, 'can we please have this now, and that now and the other thing'.

Dr SEIDEL - I have tried for this many times before.

Dr JACKSON - It requires a 'can do' attitude in the context of what we want pharmacists to do, instead of a risk-averse attitude to pharmacist practice, which has been the predominant attitude over the last 30 years.

CHAIR - Which I find staggering as a health professional myself, in that what you have to know about every drug, every interaction, every side effect, every benefit, all that, but you cannot actually use that skill to full capacity.

Mr GAFFNEY - I may have missed this but other than the governments, both federal and state, are there any other groups that you find are not helpful in the pharmacist's pursuit of this? Or, are there any other groups that are helpful and would provide support for what you are trying to do? It is a two-edged sword there.

Dr JACKSON - The other group that could have a significant impact on the ability of pharmacists to support their communities is Primary Health Tasmania. That is the other organisation. You might rank them in the context of one and two being the Commonwealth and the Tasmanian health departments, but a clear number three, well above any others. is Primary Health Tasmania. In the context of collaboration, in the context of integration and in the context of service delivery, they could have an extraordinary impact.

Mr GAFFNEY - Okay. If a group was going to find out that there were any groups out there that would not be supportive, would that be apparent in Tasmania, or not?

Dr JACKSON - I think you would find that the medical groups organisationally may put forward some barriers. Again, over the last 18 months, I think we have seen some of those barriers being broken down, primarily because we were all busy; we are all worn out and we are all a bit burnt out. They want some help, but old habits can die hard.

Mr GAFFNEY - Or they retire.

CHAIR - We have run out of time. Are there any closing comments you want to make, something you wish you had said and haven't that you can think of at the moment?

Dr JACKSON - No. I thank the committee and you as Chair for the opportunity to be able to be able to talk to you.

CHAIR - We will certainly have a thorough read of the additional information you provided.

THE WITNESSES WITHDREW.

Ms JACKIE SLYP, CEO ARTHRITIS AND OSTEOPOROSIS TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Jackie. Thank you for your submission and appearing before the Rural Health Committee today. This is a public hearing. It is being transcribed for Hansard and broadcast as well. Everything you say here is protected by parliamentary privilege. That may not extend when you leave the room. If you have anything of a confidential nature you wish to share you could make that request to the committee and the committee would consider that, otherwise it is all public. It will be transcribed and put on our public website.

Do you have any questions before we start?

Ms SLYP - No, it is all straightforward. Thank you for the opportunity to come along and present personally.

CHAIR - Do you want to introduce yourself and speak further to your submission.

Ms SLYP - Thank you. All my working life has been in the health sector. I have a post-graduate qualification in health promotion. I started off with state Health, worked for about 20 years in policy, industrial relations, did a stint with a health minister in the Field Labor government, then went back to Health for a while and ended up managing the then Division of General Practice with Geoff Chapman. I came in at the very early stage. There were only about 2.1 FTEs at the time. By the time I left we had 19 FTEs and the role had changed dramatically and went on to be what is now Primary Health Tasmania.

I looked for a non-government organisation and found the Arthritis Foundation of Tasmania. I have been there now just 20 years in the role of CEO. I am passionate about particularly the health of older Tasmanians and making a difference to their lives and wellbeing.

The thing with arthritis is that it is one of the most disabling, painful and chronic conditions that you can get. Yet it is so misunderstood; it is often trivialised and not taken seriously at all. We get that every day. Our role as an organisation is primarily information. It is filling the gap between the individual and their role with the health care system. We have the time that busy health care professionals and medical practitioners do not often have.

We do not provide case management services. We only do broad population, education and awareness. We are looking at assisting individuals to be able to live well with these conditions, to look at how we can give them confidence to ask the questions they need to ask, to look at a plan to be able to give them skills and techniques to self-manage their conditions. What compelled me to put this submission in was the absolute frustration at what we are seeing in the health system at the moment. We are constantly getting people calling in on our 1800 number or coming to us in other ways who really have nowhere else to go.

If you are living outside of the Greater Hobart area at the moment you have no access to specialised rheumatological services. Even in the Allied Health sector, which we desperately need to have bolstered, we are not getting that specialist understanding and knowledge around arthritis and musculoskeletal conditions.

At the moment we regularly have individuals, we recently had a number of case studies - I could have a novel filled with these. These are not old people per se. These are young people who are trying desperately to stay in the workforce. A painter on the north-west coast of Tasmania has developed pains in his hands and neck for some time. He is employing a person, he has an apprentice still on his books. He has been to his GP who quite rightly has said he would need a referral, he has an inflammatory type of arthritis. But where does he send him? I am told the outpatients clinics at the Royal are only open to people living in the southern area. I understand that; they do not have the capacity to broaden it out to north, north-west. This is where they go. They sit on those waiting lists.

That gentleman is not considered to be an urgent case. His would be in the second categorisation and so he is still waiting to come down. He is able to afford to travel down to Hobart but if you are in pain and you are stiff, the last thing you need is a three-hour trip in a car and then heading back. You need overnight accommodation. That is if you get an appointment at the outpatient clinic. Patient travel assistance is only payable for people who see someone at these outpatient clinics, so there is a disconnect there. The majority of people cannot afford to see a rheumatologist in private practice. The individual rheumatologists that we do have do make exceptions on a number of cases.

This is the issue too. These people don't show up because they are not bed day numbers. They are not blocking up the beds in the state health system. These people go under the radar. Nobody is looking at that gap, apart from outpatient clinics that are stacked up to ridiculous levels. These individuals are not waiting for beds in hospitals; that is the last place we need to see them go. We need them to be put onto a pathway to obtain the necessary specialist diagnosis and access to the treatments that are available.

There are a lot of very positive things happening for inflammatory arthritis, if you can get access to them. All the clinical guidelines that we have, and best practice is that these people must be seen promptly. We need to stop this inflammatory disease in its tracks, and that is often hard and fast medication, which then can be pared back as the disease is slowed down.

I apologise that I am a little passionate, and sometimes get a bit carried away with it, but I really see that there is so much that can be done, and it is not costly. That is the frustration as well.

I can, in terms of questions, go through a number of other case studies and again these are young people in the workforce, and older people. But the issue with not doing anything, if we do not get some support for these people living in rural communities, they are going to end up with joint damage that can be absolutely avoided. They are going to end up as often on that well-trodden pathway to elective surgery.

Then again, we see government throwing a big bucket of money at it. 'Oh we've got to get this elective surgery down'. We find with the right allied health support in that primary health area, a lot of these people can delay the need for surgery because if they are engaging in strength exercise, they are building the muscle strength around the major joints, and so, therefore they are supporting those joints.

I really feel for GPs, because they do not have a lot in their kit bag. They know there is a great waiting list up here. They only have medication and surgery referrals, and you have

someone sitting in front of you with chronic pain, stiffness, fatigue, and they are not going to feel satisfied unless they leave with something. There is still that mindset, I think, that you know, if I don't come out with a script or a referral, or something, then, you know. And we get that as well.

We try to get people to think about a pathway that is outside of those areas. Yes, surgery is very often the right thing to do, but I think is all too often the very quick and easy thing to do.

CHAIR - Thanks Jackie, I just want to take one thing, and I come to you if you might. There is lots of things. The submission is very helpful in addressing the terms of reference, thank you for that.

The patient transport scheme, do you want to elaborate any further, because we are hearing from particularly our isolated communities, but you talked about the painter from the north-west. If he has to access a private rheumatologist, then he does not get any financial support for that.

Ms SLYP - Not to travel to Hobart, no. So, what we are getting, and I did actually point out to the service, an anomaly in their guidelines, which was very quickly fixed. I perhaps should have left it there. But, unfortunately no, to get any cover they need to see a rheumatologist in the outpatient clinics; otherwise, they are only funded as far as Launceston, where we have a private rheumatologist. Unfortunately, many people cannot afford the fee to see that individual, and that individual also does not, I understand, have a connection with the Launceston General, so we are not getting that follow-through that you would want in ongoing care.

CHAIR - Did you say that it has been corrected now, and they do provide it?

Ms SLYP - No, they don't. The last -

CHAIR - This particular person went from the north-west through to Launceston, where they are eligible on the base of how far they travelled to access PTAS. If they chose, and somehow find the money to pay for the private rheumatologist, they still would not be eligible.

Ms SLYP - In Launceston, no. They would not, because they are seeing a private.

CHAIR - There is no public service there.

Ms SLYP - There is no public service in the north or the north-west.

Ms LOVELL - So, the only way to get patient travel assistance is to go to Hobart to see the public rheumatologist?

Ms SLYP - It is to go to Hobart to see the public rheumatologist in the clinic.

CHAIR - But they closed their books for northern people.

Ms SLYP - However, what is happening is the people who manage those clinics are putting people in, because they see the difficulty these people are having. I have said to them,

look, in order to highlight this gap, you need to not accept people. But that is hard when you are dealing with real people.

CHAIR - And you see the prevention.

Mr GAFFNEY - How are you funded and how many FTEs do you have so that I understand how that works?

Ms SLYP - We are micro-small. We're very grateful for some funding from state Health. That is a three-year funding agreement we have at the moment so we have about $120 000, which, as I said, I'm extremely grateful for. That funds an educator position within our organisation and some support services around that, in terms of having an office to sit in, a computer, et cetera. Other than that, we have three part-time staff and I am the only full-time person. I did drop back to part-time because we were having difficulties covering our costs but the board of Arthritis Tasmania has said, 'Just go full-time and if we have to go out the door and shut the door, we do'.

Everything else we have to fundraise for. It is tough and arthritis is not high on that hierarchy of disease. Some people wear chronic conditions like a badge and I am not saying those are not important issues, but arthritis is not one people get excited about, even though it affects right down to babies to older people.

CHAIR - Diabetes has a much more public profile, for example.

Ms SLYP - It does, or MND or breast cancer. People will tell you all about their dicky knee at a community expo but then they will donate their $20 to cancer. Good luck to them. That's fantastic. But we find it difficult and, certainly, without our volunteer team - we have 24 active volunteers - we would be lost.

Mr GAFFNEY - On that, you said you had a three-year funding. Do you have to go back cap in hand every three years?

Ms SLYP - Yes, and do a business case. We are very proud of the outcomes we do. We have very tight KPIs. We are very switched on in terms of the difference we can make and we have innumerable case studies and that type of thing to demonstrate that. But it's tough when you have so many different things wanting.

Where I think the difference can be made is looking at the partnership approach. We definitely try to work jointly or in partnership with other organisations. Sometimes we do struggle with that. There is still a bit of a territorial thing. I think that's driven by the fact that the funding cake is tight.

Even though I have worked with the Division of General Practice, which is now Primary Health Tasmania, we have had no luck in engaging. Musco-skeletal is never on the priorities list. It is generally mental health and a range of other conditions, which are very much needed. What I often say is that musco-skeletal conditions underpin a lot of the other chronic conditions. People's emotional and mental health is an enormous part of living with musco-skeletal conditions. If you are 25 and you've just been given a diagnosis of ankylosing spondylitis or another inflammatory arthritis, suddenly there goes your footy, 'I can't get in the truck to work

in where I am, so my job is gone'. This is life-changing stuff and these individuals find it extremely hard to deal with and there's nowhere to go, really.

Mr GAFFNEY - My last question to that, we know that arthritis is not going to go away. It is going to be here forever. It is the same thing when every three years it takes time to prepare submissions and give case studies and so on. Sustainability of your organisation, when you retire, Jackie, which is going to be on the cards, what happens there if there is no continuity of funding? Would you like to make a comment on that? What would make it easier for your organisation into the future.

Ms SLYP - Certainly, some surety around funding. We live hand to mouth. The organisation is 45 years old. I knew that when I went into it but I thought with my skills and experience, I could make a difference but I can't perform miracles. I wish I could. Succession planning is constantly on the agenda for our board and even for our educator position because you have that knowledge within only a small number of individuals. I thought I'd only stay with the organisation for five years. I'm by no means irreplaceable. Everyone is replaceable but I do feel that, unfortunately, I do carry quite a bit. What would make it easier is really just that recognition that this is a legitimate condition where we can save money in our health system.

CHAIR - In the acute sector?

Ms SLYP - Yes. If we invest in the primary health sector and in organisations like ours, you can save money later on down the track in the acute sector.

Dr SEIDEL - I'm going to make a controversial statement. I'm wondering whether we are actively discriminating against patients with inflammatory arthritis. The reason why I'm saying this is that people have rheumatoid arthritis. They are generally younger people, often women, but not predominantly. As you said, if you don't hit them hard and fast with nonsteroidal medication, modifying drugs, they actually die 10 years earlier compared to the equivalent person who doesn't have the same condition. They die, it's not dodgy knee, it's death.

The problem is we only have access to public service in the south, not in the north, not in the north-west. I imagine that's discriminatory. Even worse, GPs can't prescribe them. In order to get those nonsteroidal drugs, you must have a specialist appointment. So, if you're in a rural area such as Zeehan or Queenstown where often GPs come and go, the diagnosis is delayed for starters before their referral is being made. Then it can't be a local specialist, it has to go to Hobart and even they are blocked.

Are we discriminating against people with inflammatory arthritis who must be on nonsteroidal drugs that are funded through the Commonwealth and we don't allow them to have access to them?

Ms SLYP - I think that's a fair comment. I hadn't thought of it from that perspective before. Yes, I think you're not too far off the mark because we're not allowing those people to access these medications that are available on the PBS and need to have that.

CHAIR - It's not about allowing them. The right term is not 'enabling' them.

Dr SEIDEL - That's why I'm asking. What are we doing here? We're not supporting them; no public transport, no public specialist, no public partnership for the one especially in the north.

Ms SLYP - Yes. Through TasReach, there is a Launceston-based rheumatologist who travels to various areas. We've had at the website. I think there's about four visits to King Island, 10 visits to Wynyard and one maybe on the west coast.

CHAIR - You have six in Queenstown in your submission.

Ms SLYP - Yes. We contributed to a needs-assessment for that organisation several years ago. It does not correlate with the needs in those areas. I think it's more of a convenience in terms of the arrangement.

Also, I haven't been able to assess what the cost is of seeing that visiting rheumatologist. There is no necessity for that service to be given at a public low cost. I suspect it's a much higher cost but that's something that we're not privy to. I think a very few individuals may get a platinum service in those areas and a regular visit. Lots of people don't get any.

CHAIR - TAZREACH funding here is limited. Circular Heads is not included, the east coast is not included in there.

Ms SLYP - There was a specialist rheumatologist who came from Barwon Health down to St Helens several years ago but I understand that no longer happens.

CHAIR - You're not sure whether the patients who get to see this specialist are funded or not? The service is funded through TAZREACH. Is there an out-of-pocket expense for the people they see?

Ms SLYP - I haven't been able to ascertain that and when I have engaged with the GP practice, generally they organise the appointments et cetera. The TAZREACH funding just covers travel costs and accommodation for the specialist. It's not passed on as far as I am aware to subsidise the visit cost.

CHAIR - So the patient might still have to pay whatever the amount is to see -

Ms SLYP - I think they have to pay around $300-plus.

CHAIR - So that's not accessible then?

Ms SLYP - No, it's not.

CHAIR - Certainly not in the areas in Queenstown?

Ms SLYP - No.

CHAIR - King Island maybe but certainly not Wynyard and Queenstown.

Ms SLYP - Yes, and that's the case studies I get time and time again. People cannot afford the specialist cost and one individual was in absolute persistent pain and so was then

directed to a service in Launceston, which was a private laser clinic. They paid $400 for a service that really did nothing and that was a huge financial cost for that individual and it wasn't what they needed. It was just 'okay, that's what we have got there'. We also have others. One young person who has had pain, and quite possibly inflammatory arthritis, for 20-odd years but the GP in her local community changes as often is the case so she's had no continuity of care. She has never had that referral to a specialist so she's very likely to have had significant joint damage by this time.

Mr DUIGAN - Jackie, I am interested to know whether Tasmania is particularly peculiar in its lack of services, or is this something we are seeing more broadly across the country?

Ms SLYP - Tasmania is certainly the only state that I am aware of that has no model of care for arthritis and musculoskeletal services, and my colleagues in the Arthritis Foundation have participated in the development of these plans. Certainly, New South Wales and Western Australia have excellent models of care. These are not difficult things to put together. Several years ago we were fortunate to be invited by the Tasmanian Health Service to sit around the table and look at developing a statewide plan as part of the musculoskeletal CAG, clinical advisory groups, that did exist at the time.

We have put in an enormous effort, along with everyone else around the table, very passionate allied health workers, who see the difference we can make. I think that was one of the very few plans that didn't require a huge investment of money for very expensive tertiary equipment and additions. It was, at the time, only a couple of million dollars but would offset an enormous amount more in cost savings.

CHAIR - When was that, Jackie, did you say?

Ms SLYP - That was the clinical advisory musculoskeletal plan. The person who was driving it went on to move to South Australia and so the wind went out of its sails and it never really got to the minister, Mr Ferguson's desk.

CHAIR - So it was when Mr Ferguson was minister, so that's the era? Right.

Ms SLYP - Yes, and I have tried to follow it up a number of times and had meetings. Now, there was a whiff of that plan - if you can indulge me for a minute - in the statewide elective surgery four-year plan that was put out by government in August 2021. There was a whiff of those recommendations in here. Part of that was that musculoskeletal triage assessment service which would just be so good for GPs out there. They would have a very clear doorway into these services whereas at the moment there are that many different referral pathways and the majority just give up because they think, how are you ever going to get through that waiting list? They try to manage them, and often do a good job, but manage them themselves.

That was included and also some joint assessment services. There is no funding. It is 2021 to 2025. I want to see some confirmation that this is funded and this is going to happen and not get to 2024-25 financial year and still is not here, you know.

Mr DUIGAN - Does that plan require more rheumatologists? Where do you go to get a rheumatologist? Are they hard to get? Where are we training them?

Ms SLYP - No, they are not hard to get. Well, yes and no, I have to be honest. Yes, they are hard to get, but at the moment, I think, in the health system we only have something like 1.5 FTE.

Mr DUIGAN - In the health system?

Ms SLYP - So, we have got in the health system, in public rheumatology services, supplemented by those in private practice. Hilton Francis is about to retire, well, he retired from rheumatology some time ago but kept his persistent pain. He is now retiring again. Also Professor Graeme Jones has pretty much relocated to northern Queensland. We have a couple of newer younger rheumatologists who have come into the Warneford Practice, but these are in private practice. These are not in the Royal in the public system.

Ms LOVELL - Jackie, that was one of my questions. Is there a shortage of rheumatologists? Are we just having difficulty attracting them? Is there a training pathway into the public system as opposed to private? Is it a training pathway issue?

Ms SLYP - I do not believe so. We see the med students every year in fourth year and we are trying to get them to sign a thing that says they will choose rheumatology. We work very closely with the Australian Rheumatology Association, and, certainly it is very attractive to come to Hobart and to work. I have not seen any recruitment happening in that area. That is the same with the physiotherapy. We have one very well experienced physiotherapist in the public health system at the moment with rheumatology knowledge. When she retires that is going to leave a massive hole. There is no succession planning there for the physio.

Ms LOVELL - Can I just go back a moment: you said you have not seen any active recruitment happening. There are not vacant positions that they are not able to fill? There are just not funded positions.

Ms SLYP - I would say there are vacancies there, but I cannot say that with any degree of confidence because I am not privy to that information. Certainly, even the other positions, every February, I think, there is an opportunity to look for a registrar position in rheumatology, and I know that there is a number of occasions when the paperwork has not been done and we have missed out on that.

Ms LOVELL - Paperwork has not been done by whom?

Ms SLYP - By the hospital system, and has not gone up through. It has been done in the department, but it has not gone up through the system to get the tick to be able to put in a bid for a registrar. If you have a registrar here, then you have a much better chance at keeping that person on.

CHAIR - But you cannot have a registrar if you have not got specialists to supervise.

Ms SLYP - Exactly, that is right.

CHAIR - On a similar, but another barrier, you talked about referral to tertiary care. It is on page 5 of your submission. You talked about early diagnosis and that access to specialty services is critical to avoid or limit irreversible joint damage. You also make the point here

that, the PBS mandates six-monthly rheumatologist reviews to all patients receiving high cost medications.

These are the patients who have been lucky enough to get on a rheumatologist's books, if you like, and so, that requires them having six-monthly reviews, which I assume means meeting with the rheumatologist, not just saying, 'yes sure, continue'. This is 25 per cent of the rheumatology practice for the patient population there, that comprises 25 per cent. Clearly, a number of appointments for the rheumatologists we have are being taken up with these people having repeat visits. I am not saying that it is not important, because they are, some of them are novel medications, I am sure; some of them are very expensive, some of them can be toxic, as other medications can. Is that a particular barrier that needs addressing, or is that purely that we need more rheumatologists in order to meet the need? What is the issue there?

Ms SLYP - The issue there, my understanding, is that you do not see a rheumatologist in the public system unless it is done through the outpatient clinic. That is the only access that you have. The medications they are talking about are what they call the new biologic medications. Tasmania has a much lower uptake of those. I would say that that correlates with the fact that you do not have the specialist access. Therefore, we are denying people access to something that can make a significant difference. If they get the right combination of treatment, there is even talk of remission in some inflammatory conditions. That was never heard of when I first started 20 years ago. There have been enormous steps forward, but we are not able to access those.

Most of the people they would see urgently through the outpatient clinics are newly diagnosed children. The decks are cleared for young people with inflammatory arthritis so we can get them in as soon as we can, but those pathways still take a long time.

In answer to your question, I would say a lot of people just do not access those. If they do get the new biological medications, they go without everything else to pay for that specialist appointment in the private sector.

CHAIR - Those who do manage to get them are mostly through the private sector, not through the public?

Ms SLYP - Those do, and they're the ones who go without other things in their lives to cover those appointment costs.

CHAIR - You noted that the current waiting time for non-urgent cases is 769 days. Referrals are apparently no longer being accepted, so it becomes a never-ending number. The estimated wait time for semi-urgent cases is 139 days, and for urgent cases, 175 days. Am I to assume that the urgent cases are the children and young people who are still waiting 175 days?

Ms SLYP - And adults as well. If you are experiencing flares, you cannot get those flares under control until you get in to see someone to really nail it. In the meantime, those people are in really difficult situations. Most of them, as I have said, have inflammatory conditions and are in the workforce. They would be in the up to 45 to 47 years age group. They are the ones that are nursing, who can't do their shifts because they are in so much pain - that type of thing. There are so many people who aren't on those, because -

CHAIR - It is only the tip of the iceberg.

Ms SLYP - That's right. People just don't bother making appointments. GPs don't make the referrals because there is no way of getting through. We get that message all the time. The GP says, look, there is such a waiting list that it will be months or a year or more before we get in. That's the reality. I really do feel for those people who have nothing in their kit bag. Osteoarthritis is even worse, because nothing new is happening in that space.

CHAIR - You also talk about, under part B, Primary care, allied health and general practice services - and you have spoken a little on this already - how there is no coordinated framework for delivery of arthritis and related musculoskeletal services across the state. You said there are significant benefits to be gained from expanding the rheumatology nurse practitioner role. Do we currently have rheumatology nurse practitioners, and how many - or not?

Ms SLYP - We have one person part-time, and recently a second person has come into the role, so together one full-time equivalent. That person is almost 100 per cent of the time busy in the outpatient clinics, or in emergency as well when people come in there. It is at least someone to go there. On top of that, they are also available to respond to GP inquiries, but that isn't well known. A lot of research has gone into this around the country, showing those positions can improve service delivery and save money. It takes a long time to be trained up in those positions, but certainly, cost-effectively, that's a good way to go.

CHAIR - They are employed by the THS?

Ms SLYP - It is, finally. It used to be funded together with a bit of money from hours left over from the hospital rheumatology position and a bit of drug company funding. We hatched it together for years, until finally the department took it on board and covered the cost.

CHAIR - How broad is the scope of those nurse practitioners?

Ms SLYP - I'm not able to talk about that to any great degree. I would have to seek advice on that, but they give a lot of the injections. And that's the other thing. A lot of these things people have to travel to the Royal - why aren't we using GP clinics in these areas? People are driven all the time into Hobart, but it doesn't necessarily have to be there. It's a pain to get a park. So many things just do not add up.

CHAIR - It's also a long and painful drive from Circular Head or Strahan.

Ms SLYP - Absolutely, yes.

Dr SEIDEL - Was the organisation involved in developing the Tasmanian HealthPathways?

Ms SLYP - Yes. We push our way in whenever we can, so we approached Primary Health Tasmania and said we have something to contribute to this. We did the juvenile arthritis one and the osteoarthritis, and whatever there was in relation to arthritis in musculoskeletal we contributed to. I really do not know how many people reference those. When you have someone in front of you, I don't think people race to get their management guidelines or their pathway. You have to be more practical about what you offer people.

Dr SEIDEL - There are meant to be locally agreed guidelines, but it's really hard, you don't have any specialist on the -

Ms SLYP - That's exactly right, yes. There are other avenues, and this is probably very typical of the way small charities are going disease-specific now. We see government moving towards 'bigger is better', and to consortiums, and so a number of consortiums are funded to deliver musculoskeletal in Tasmania through the Primary Health Tas tenders for chronic conditions - and those tenders were way outside our capacity to contribute to. It would've taken many, many hours to put in a tender. But as soon as other organisations did come on board that tick the musculoskeletal box, we contacted them and invited to meet with them and share our resources, but we haven't had any of those three organisations take up, so we have no idea what they are doing in those areas. It is just an opportunity lost.

Dr SEIDEL - You mention that certain treatments are only being given at the Royal Hobart Hospital. I think one example is infliximab, which has been used for ankylosing spondylitis and rheumatoid arthritis as an infusion. I think you are right - rural people are being asked to go to the Royal Hobart to have the infusion there, although the same infusion could be delivered through the THS pharmacy, to any location the patient could be closest to. Right?

Ms SLYP - Absolutely right. In fact you have just prompted me to one situation where we looked at the bed days around these conditions at Launceston General. This is some time back, but I doubt if it has changed. There was an individual who travelled from Campbell Town who had to be accommodated overnight at the Launceston General for their infusion. Now, why can't that be given at a rural location? With a little bit of training, that could negate that person having to travel, and I bet there are many examples of that.

Dr SEIDEL - I am aware of a patient from Bruny Island who was also being asked to travel off the island to stay overnight at the Royal Hobart, where the request specifically was made for the infusion to be administered on Bruny Island.

Ms SLYP -Yes, you are right.

Dr SEIDEL - The last question I have is that there does not seem to be a shortage of rheumatologists, but they just work in private practice? I can't see a current vacancy for a rheumatologist anywhere in the state. Why do you think people chose to work in private practice, rather than looking at employment in the public service?

Ms SLYP - My take on that is because there is a lack of a team around that individual or individuals. Ideally, you have not just the rheumatologist clinician but your physio, your OT, nurse practitioner. Often people have these multi-needs. It is not always having to see the clinician. They are the lead but over 20 years I have seen a real obvious deterioration in the specialised services that are available for these conditions. They are becoming more generalist in allied health. I am not convinced that is affording people the service that they should be getting.

We became a registered training organisation 10 years ago because we were desperate to diversify our income streams and look at where we could increase our money. We knew that we had knowledge and experience. We got some pro bono support and we became a boutique RTO, a not-for-profit RTO. We constantly get, not so much from Tassie but other states, fitness leaders, nursing, physio, EPs, who are desperate for additional knowledge around

musculoskeletal conditions and around exercise and arthritis and those type of things that we offer. That's a little growing stream but we don't have a lot of money to advertise that. It's word of mouth. It is helping us offset that gaping hole where the fundraising dollars used to go.

CHAIR - On the front page of your submission you have three recommendations which you have broadly talked to. Are there any other things that you think beyond those three, which obviously you have spoken about, that would make a significant difference? What would you prioritise above other things to make a difference?

Ms SLYP - Those recommendations certainly capture the key things. While they have elements of those included in the statewide elective surgery four-year plan, I want to see some surety around that. I really want to see commitment from government to getting that done and not waiting until it peters out. Every charity pitches for its own support but I feel it would leave a significant hole in what people could do. We don't have a magic wand but at least we listen to people, we help them navigate through the system. We give them a little bit of hope. In the meantime, we try to work with them to give them a plan and some confidence to move forward.

CHAIR - Until they get to the point where they need surgery, this is a primary health matter with very clear preventative measures that can be taken to slow down the progress of the condition. Whose responsibility is it to fund the work that you do and ensuring that there are adequately trained nurse practitioners and rheumatologists available and a mechanism is in place that enables infusions to be given in our regions?

Ms SLYP - Wouldn't it be amazing if we were to be able to get some funding through Primary Health Tasmania. That's the most obvious organisation. We would be able to provide a real statewide service because I would be able to have educators in other areas that could then work in partnership with local allied health providers and create those local pathways. That's where we should be coming from. This tick-the-box approach that we have - I'll do musculoskeletal and I'll do diabetes and what have you - allows government to say they're doing that, but what is doing that? There's no quality.

CHAIR - Primary Health Tasmania does get buckets of funding from time to time. They have even got quite big buckets at times from the federal government. Have you applied for funding for the things you have talked about?

Ms SLYP - Absolutely. The main answer I get is that it is not a priority for their needs at the moment. It is not on their strategic future plan. They are covering the plans on musculoskeletal with the tendered organisations at the moment. We are not getting a look in. The only funding I have had from Primary Health Tasmania in the past five years was $300 accidentally deposited in our account and it had to be paid back.

CHAIR - Finders, keepers.

Ms SLYP - We put some very good plans to them about fracture in osteoporosis fracture prevention, where we would work with rural GP organisations. We work very closely with Menzies. We had a mobile machine. The purpose was not diagnostic. It was more to get people in the door and get the conversation started. We had a well laid out plan with great KPIs, outcomes, it was not that expensive. Could not get a gurnsey.

CHAIR - It was not sexy enough.

Ms SLYP - No, perhaps not. Or maybe it did not hit the current -

CHAIR - You made the point of the outset. If we could go back to that. At the moment, rightly, there is a great focus on mental health and wellbeing. Other things like diabetes and other forms of cancer get a higher profile. However, this has equally debilitating impacts on people's lives, and potentially a cost to the state acute health system. What needs to happen to make that people are aware of what this looks like and what it means?

Ms SLYP - I think it is banging in the drum. At every opportunity we try to sit down. I have not yet been able to get an appointment with the new Health minister, despite letters. I have managed to sit down and talk with her advisor, but the attitude towards these conditions is just so dismissive. It is not important, it is trivialised, it is the elephant in the room.

CHAIR - Until you get it yourself.

Ms SLYP - Exactly. That is what we don't have.

CHAIR - There is a federal election coming up. Maybe you could talk to all the candidates.

Ms SLYP - So, we will back on it again. Yes, it is surprising just how many think, 'This is not about me, it's about older people'.

CHAIR - It is not just about older people, it's about children, it's about women, as Bastian described, who die.

Ms SLYP - Yes, that is right.

CHAIR - Let's run a gender lens over this, shall we? Where's the gender impact on this? Have you done a gender impact assessment of the condition?

Ms SLYP -No, we have not.

CHAIR - It would be worth doing that.

Ms SLYP - Very much so. It is prevalent with women. It was only two years ago, prior to COVID-19, that we took 10 children to Bonorong Park for a family day out where we connect families with young children for support. We had 10 little girls aged from six to nine years. That is sad that we were able to easily get together the group. What we were only able to do was connect them for support, so they could talk to each other about how to handle the injections and that type of thing.

CHAIR - I encourage you to do a gender impact assessment and then approach the Minister for Women, as well. We are a little bit over time. Is there anything else you desperately want to say that you haven't?

Ms SLYP - No, I think I've got across. Thank you so much for the opportunity to talk to you. I would be more than happy to answer any other questions in future. If I don't know the answer I'll find it out. Thank you very much.

CHAIR - Thank you. It was a very good submission in terms of addressing the terms of reference. I appreciate that.

THE WITNESS WITHDREW.

Ms COLLEEN JOHNSTONE, CEO, PALLIATIVE CARE TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome Colleen to Rural Health community hearings. We appreciate your submission and you taking time to appear before the committee. Everything you say here is part of a public hearing and will be recorded. It is being broadcast as well and transcribed by Hansard and will form part of our public record. Everything you say is covered by parliamentary privilege while you are before the committee but that may not extend beyond the committee hearing. If there was anything of a confidential nature you wish to share with the committee, you can make that request and we would consider it. Do you have any questions before you start?

Ms JOHNSTONE - No, thank you.

CHAIR - Okay. I invite you to introduce yourself and speak to your submission and the members will have questions for you.

Ms JOHNSTONE - Thank you for inviting me to appear today. I am the CEO of Palliative Care Tasmania, the state's palliative care peak body. Every jurisdiction has a palliative care peak body and we are represented nationally by Palliative Care Australia, our national peak body.

Palliative care is very important not only to me but it should be important to all Tasmanians, as 85 per cent of Tasmanians will need palliative care. Further, 100 per cent of Tasmanians will interact with palliative care whether that's through caring for a dying parent, partner or child, friend or neighbour.

I will start by giving you some of the Tasmanian context and then looking at some of the specific issues that impact rural communities broadly across Tasmania.

Every year in Tasmania at the moment we have approximately 4000 expected deaths. This is increasing. KPMG estimates that we are looking at an increase in demand in the need for palliative care by 135 per cent over the next couple of decades and that is primarily due to our baby boomers starting to die. Up to 90 per cent of people with life limiting conditions would benefit from palliative care but unfortunately in Australia and in Tasmania, only about 50 per cent of those people actually receive palliative care. Our demand, as I said, is increasing and the Productivity Commission also describes Australia as facing a tsunami of palliative care cases in the upcoming decades.

In Tasmania we have a greater proportion of people over the age of 65. We all know this. We know that we are an ageing population in this state. As we age the life limiting diseases that impact us also increase so we have some of the largest rates of dementia in this state. Dementia is the second largest killer in this country and through illnesses like dementia, we also can suffer multi-morbidities which require more complex care, so our palliative care needs increase as well.

We know that the east coast of Tasmania has the highest rate of older Tasmanians living there and also has the highest rate of palliative care demand per population. Not all Tasmanians who need palliative care can access it and this is particularly true in home and community settings and it is more pronounced in rural communities. I also note that the delivery of

palliative care is not just a role for our healthcare system or our specialist palliative care services; it includes significant contributions from our informal and formal community supports. Every single person has a role to play in palliative care.

Some of the barriers that people face is that they want to be supported at home, however home is defined. It could be your house in the suburbs, it could be your residential aged care facility, it could be your disability share house. This is really tricky to provide in Tasmania. For example, in Tasmania in the last weeks of life the preference for home care falls from 90 per cent to 52 per cent and this is mostly due to issues relating to symptom control and management. While people want to die at home, they don't feel supported to do that and the most common place of death for dying Tasmanians is still hospital with about 40 per cent of our dying Tasmanians still dying in our three major hospitals.

Rural Tasmanians experience poorer health outcomes. They generally have poor access to local GP services, lower access rates to specialists and it is more common for rural Tasmanians to have more advanced stages of disease before they can access support and this includes palliative care. It is important in rural Tasmania that our dying Tasmanians have access to a workforce that is part of their community so that they build that trust. When you are dying you are at your most vulnerable and it is really important to have that trust, particularly from your local community to support you.

The Government has recently made some commitments about community palliative care and also after-hours palliative care, which is very welcome. However, GPs are at the forefront of our community palliative care. We need to support our GPs more effectively. We need to do this through professional development, access to palliative care multidisciplinary teams but also from a national level. Our GPs are not remunerated to provide palliative care in people's homes or for after-hours so it can be very cost prohibitive for GPs to be able to provide palliative care after hours and in people's homes.

The Palliative Care Outcomes Collaboration (PCOC) which is a national benchmark in palliative care dataset, funded by the Australian government, run through the University of Wollongong, suggests that GPs rate fourth in terms of referrals to palliative care services. This is after hospitals, after aged care facilities. They think that is because primarily, as we discussed, GPs need to have greater access to professional development in palliative care and increase their experience in palliative care and also the issue about local service availability. It can be very tricky for a GP to refer a patient to palliative care if there are not the services to refer that patient into.

However, PCOC also says that when GPs are trained in palliative care, they report palliative care symptoms more effectively than the national benchmarks. It is really important that we get the remuneration piece right for our GPs so that they can operate effectively in our communities but also that we provide them with access to training, professional development and that experience piece.

In terms of our palliative care workforce in Tasmania, we have approximately 49 000 people in our workforce. That is nearly 10 per cent of our population so if we think back to 85 per cent of Tasmanians will need palliative care and 100 per cent of us will interact with palliative care, that makes sense. Our workforce is separated into four segments: our specialist workforce which is our three specialist palliative care services and our palliative care units across the state, generalist palliative care which are our GPs, our community nurses and

other medical professionals who provide palliative care, our community palliative care which primarily includes community services like you would experience from the Cancer Council, Leukaemia Foundation, the MMD, Palliative Care Tasmania and our massive unpaid workforce. In rural Tasmania it is our massive unpaid workforce that does most of the heavy lifting.

Our specialist palliative care workforce is 0.4 per cent of our workforce, generalist is 37.2 per cent, community is 20.7 per cent and our unpaid workforce is 41.7 per cent. We have approximately 1870 services and in terms of our regional spread for specialist palliative care, 40 per cent are in the south, 40 per cent in the north, 20 per cent in the north-west. For generalist palliative care, 52 per cent in the south, 28 per cent in the north, 20 per cent in the north-west. Four our community palliative care, 53 per cent in the south, 33 per cent in the north, only 14 per cent in the north-west and for our unpaid carers and our volunteers, 57 per cent in the south, 29 per cent in the north and gain only 14 per cent in the north-west.

We have key workforce shortages across these segments and this impacts the ability of our dying rural Tasmanians to access palliative care. We have a lack of skilled workers, particularly in nursing and medicine. We had this before the COVID-19 pandemic hit and the pandemic has just exacerbated the situation. We don't have consistent 24-hour access to palliative care service. At the moment in Tasmania we have a phone number. I understand that the Government has invested funding to address that situation but as we speak now if you are dying in Smithton, it is unlikely that you will get after-hours support.

We have a lack of nurses for one-on-one care at end of life. We have a lack of skilled workers in age care and allied health. Age care is the second largest place of death in Tasmania, and in Australia. We have a lack of care coordination. Because we do not have care coordination in palliative care, when people are discharged from hospital they feel like they are falling off the cliff. They don't know how to access services. They don't know what services are available. The don't have somebody that can wrangle services for them.

There is a high turnover in our workforce, particularly among support workers. We have a lack of palliative care skilled mental health professionals. We have a lack of carer respite. We also have a lack of career pathways into our sector for carers. Our unpaid carers learn an invaluable amount of skills when they are caring for their dying loved ones. We also have a lack of mental health support for carers.

Regarding our system issues, we do not have 24-hour palliative care services. It is very difficult to work outside the Tasmanian Health Service. We have four segments. Predominantly, those 1870 services are not THS services. When you don't have systems that talk to each other, it makes sharing information really difficult. What does that mean for the patient? It is not unusual for a dying Tasmanian to be sharing their story seven, eight, nine times every day with all of the different types of care and support people that they might see. One of the things we hear from dying Tasmanians is they just want to get on with their life. The don't want to be on this hamster wheel of sharing their stories over and over again.

We also need to look at a more timely referral process. People that are referred to palliative care, whatever that means, don't feel they can access services in a timely manner. We need to note that our specialist palliative care services across the country only see the 15 to 20 percenters, the patients that have really complex palliative care needs. Most palliative

care, from a clinical perspective, is provided in that generalist palliative care space by our GPs, our other specialists, our community nursing services and our other health care professionals.

We need more multidisciplinary team approaches across the four segments that pick up our unpaid workforce and our community sector. In rural and remote Tasmania service availability is limited. It affects not only the clinical care that is provided, a large part of palliative care is the holistic care that is provided to our dying Tasmanians.

We have a lack of community knowledge and awareness about palliative care. Lots of Tasmanians think that palliative care means that they are on their absolute last legs. They feel it is a taboo topic. Some Tasmanians are resistant to accessing palliative care because they see it as giving up. The sooner you access good quality palliative care, the better the quality of life you will have while you are dying from the life-limiting condition you have. One of the unintended consequences of receiving good palliative care early is that we tend to see people living a little longer because they are free from pain and they are still able to connect with their communities and their families.

Community attitudes and the stigmatism of palliative care are barriers, resulting in hesitancy and unwillingness to engage in palliative care. Many people believe that people with life-limiting conditions only sometimes feel like the possess ownership of their care plans and goals. This is really heart-breaking for us at Palliative Care Tasmania. All Tasmanians who are dying, no matter what their condition, should feel empowered to have control over what happens to them at the end of their life.

There are issues around communication between service providers. I have touched on that. This is a big issue that needs to be improved. Fractured integration of services is negatively impacting people's transition between services. It causes undue stress and confusion for dying Tasmanians and their families. There are different patient record systems used by different service providers, which results in gaps in information. It puts the burden on the patient. There's also a lack of awareness and knowledge between service providers about the services and support that operate outside their own organisation.

Regarding palliative care in Tasmania, particularly in rural and regional Tasmania, do we have gold standard palliative care in this state? No, we don't. If we had one Tasmanian die in the back of an ambulance because their family or their community don't understand what palliative care is or that is the only option they face because they live in rural Tasmania, that is not good enough. That is not a gold standard. Do we have access to after-hours palliative care in this state? Only if you have a good GP. If you have a good community GP, they might give you their private mobile number and your family might be able to call them after hours. That's about it. The only other after-hours palliative care you will receive at the moment is if you call an ambulance.

What do we do moving forward? Palliative Care Tasmania welcomes the Government's investment into palliative care, and community palliative care in particular. This is a first step forward in helping to address current demand. It will not address future demand. It is great for government to invest funding but if we can't fix some of these systemic issues, for example, remuneration for GPs. We expect our community pharmacist to play a role but 98 per cent of pharmacy revenue comes from dispensing prescription medication. If you want your pharmacist to talk to someone in their local community about advanced care planning or how

to access palliative care services, other issues around their life-limiting condition, or medication, they don't get remunerated for that piece.

Until we can fix some of these systemic issues and get that environment right, we will not be able to get the community palliative care piece working properly. Rural Tasmanians rely on having that community palliative care piece working properly.

I have been a little bit doom and gloom today. I am not going to apologise for that because I am telling you the system as it is. As I said, I see the Government's investment as a first step forward and look forward to working with the Government and parliament so that we can ensure all Tasmanians, no matter where they live, no matter what their background, have access to the best possible palliative care we can provide. Thanks.

CHAIR - Thanks, Colleen.

Mr GAFFNEY - Colleen, you used the term 'gold-standard'. I see it's hyphenated so I am going to ask, are there any states that are gold-standard in palliative care? Are we silver, bronze? Is there a rating scale?

Ms JOHNSTONE - Being gold-standard is about accessing palliative care where you want, when you want and how you want, when you need it. Some of the bigger jurisdictions have pockets of gold-standard, particularly in metro areas where there is service availability.

The issue of palliative care for rural Australians is very similar across the country. It is really difficult to access gold-standard or best practice palliative care if you live in rural Australia. There is no silver or bronze. Tasmania is one of the only jurisdictions that does not have 24-hour access to palliative care except we have a phone number. I would see that as a first piece in increasing our level up to a higher standard.

Mr GAFFNEY - Going from lead to something else.

Ms JOHNSTONE - Well, potentially.

CHAIR - A bit of dirt, perhaps. Plastic.

Dr SEIDEL - Thank you, Colleen, for your submission, which was really good. When you say the government is investing more in palliative care, is this actually going to areas where we have after-hours gaps? Or is it going to enhance existing services in metropolitan areas?

Ms JOHNSTONE - You would have to talk to the Minister for Health to get more information, but my understanding is that they are looking at investing some of the funding into after-hours and some of the funding into community palliative care.

Dr SEIDEL - What engagement have you had? You are the peak body for palliative care. You have consistently argued for the same thing for years now.

Ms JOHNSTONE - For a long time.

Dr SEIDEL - You state now you welcome it, but it doesn't seem to be clear where the money actually goes. It's always nice to have those lines showing we are investing X amount

of dollars, record stuff, blah, blah, blah. My concern is that we will have the same discussion next year or in two years' time or in three years' time.

CHAIR - And it's all focused around Hobart and Launceston.

Dr SEIDEL - That's right.

Ms JOHNSTONE - The Department of Health has contacted us to include us as a key stakeholder in terms of how that funding should be spent, and those discussions will take place early next year.

Dr SEIDEL - Okay. Is your priority for the bulk of the investment money to go into rural after-hours care, because that seems to be the equity issue now - or where do you think the money should be going? What would be your preference?

Ms JOHNSTONE - We argued in our previous budget submission this year, and also as part of election commitments to both parties, that we needed to have funding in after-hours palliative care, full stop - whether it is regional or metro - and also in that community palliative care piece which is primarily regional and rural Tasmania.

Obviously, this inquiry is focused on rural health services but we cannot get away from the fact that just because you live in Hobart does not necessarily mean you have greater access to after-hours palliative care than if you lived in the Huon Valley. In actual fact, if you lived in West Hobart and you don't have a great GP, your chances of accessing after-hours care - you run down to the Royal Hobart Hospital, essentially. There's no greater access to after-hours palliative care depending on where you live, except your hospitals are closer.

The community palliative care aspect is the really important piece for rural and regional Tasmania, ensuring our GPs, community nursing, and other health professionals in our rural regions have the professional development, training, the access to multidisciplinary teams. The specialist palliative care services should play a role in that.

We should have a system where, if you're a GP up in Smithton or St Helens, you can ring your local specialist palliative care service, talk to them about your patient Mrs Blogs, and be part of that multidisciplinary team approach, no matter what time of day it is. At the moment we don't have that.

Mr DUIGAN - I'm interested to know what 24-hour access to palliative care actually looks like. I grew up on Flinders Island. My parents both grew old there. Beyond the phone line, what do you get at three o'clock in the morning?

Ms JOHNSTONE - We have three specialist palliative care services: one in the north-west, one in the north, and one in the south. They are Tasmanian health services. At the moment those services primarily operate from about 8 a.m. to 4 p.m. on weekdays. We say that if you want to die in this state, you die during business hours. You don't die after hours, because our specialist palliative care services don't have the resources to provide you with that one-on-one care if you need it. When we're talking after-hours care, it's usually some type of urgent situation that can't be handled over the phone. They actually need to do a visit.

We would like to see increased resourcing into those three specialist palliative care services, particularly in nursing. For example, I believe our north-west service only has four palliative care nurses; same with our northern service. In the south, if we remove the nurses who are employed on our real palliative care unit, and just look in our community palliative care service, you're looking at around 10.

For our population, and the increased demand that we are expecting, we need to be looking at more effectively resourcing those three specialist palliative care services in the community nursing area.

We also need to look at our statewide community nursing services. For those community nursing services, based on a 2017 report from the Department of Health, 50 to 60 per cent of their role is providing palliative care. But the community nurses service tells us that the nurses do not have the professional development or experience they feel they need to provide effective palliative care. What then happens is that those patients get referred to a specialist palliative care services, which are bulging at the seams.

So, we need to ensure our community nursing services are effectively resourced and that our nurses have access to professional development. We need to also increase resourcing into our three specialist palliative care services.

Dr SEIDEL - How many additional nurses do we need? Currently, it is hard to educate the existing workforce. They are already busy and probably don't have enough time to access more education; same for GPs. So, how many extra nurses do we need in the community, and in the small district hospitals? They are all organise palliative care suites now. We have done the site visits in Dover, St Marys and so forth. What is the workforce that you actually need to do the 24/7 palliative care, to access services in those areas?

Ms JOHNSTONE - I can make a general statement and say that if you tripled the number of nurses that might just give you enough to do a 24-hour roster. But that is not taking into account leave, sick leave, and other issues. You will need to get more accurate information from the department and the Tasmanian Health Services.

Dr SEIDEL - Are you aware of any rural area in Tasmania where we have access to 24/7 palliative care?

Ms JOHNSTONE - There are pockets, but again, it really depends if you have great GPs who are willing to do after-hours. Some of them, particularly around Longford, are very good, but others cannot. We also need to remember a lot of our GPs in rural Tasmania are locum GPs. Many of our GPs are also overseas born, where palliative care is not necessarily taught as part of their medical degree.

I want to also state that every single person who works and volunteers in palliative care is amazing. They do the absolute best job they can to support our dying Tasmanians and their families. They do it on shoestring budgets. Many of them work many, many hours overtime and never seek any type of remuneration or recognition for this. But we cannot have a system that relies on the passion and goodwill of people. We need a system that is appropriately resourced.

The other thing to keep in mind, particularly in our rural areas, is that our palliative care workforce is the most ageing workforce in our health system. Many of our palliative care nurses are retiring in the next five years. If we do not take steps now, in the next five to 10 years I will be appearing in front of you again, but this time, instead of doubling or tripling our nursing workforce - in particular palliative care - who have the 20 to 30 years of expertise needed to train, our next generation of nurses will have retired.

CHAIR - Can I just pick up on this. Personally, my own family had a very good experience of palliative care, but getting in early was the thing - as soon as the diagnosis is made, as you commented, but a lot of people do not understand that. I think a body of work needs to be done around that. I'm interested to know how you think that should happen.

The other point you made was about the lack of 24-hour care. As I understand it, our community nursing services will stay with families overnight, they are not palliative care trained nurses necessarily. In order to address some of the challenges you have spoken about, should these community nurses be upskilled to actually manage the palliative care patient? The reason is that families panic in the middle of the night. When their loved one takes a turn for the worse they often do not know how to respond and they panic and it is easier during the day to get some help for that.

Ms JOHNSTONE - That is absolutely correct. We cannot get away from that professional development piece. And you are right, families panic in the night and some of that panic comes because they have not had, whether it is the GP, or the nurse, or a palliative care specialist or another health professional, explain to them that the rattly breathing noise that mum is making is completely normal; it is part of the dying process, or these other issues are what we would consider normal. We have had cases where we had families call ambulances six, seven times in 40 hours because no health professional has taken the time to explain to the family that this is what dying looks like.

CHAIR - Maybe they have explained that, but they do not remember.

Ms JOHNSTONE - Yes.

CHAIR - I was able to do that because of my background, but I had to reassure the rest of the family this is okay, this is normal, this is nothing to be frightened of.

Mr DUIGAN - To some extent, this is the cup that can never be filled, you know. It is that people are stressed and if there is someone that they can talk to or someone that would visit and come and sit with you and talk to you about it, you know.

Ms JOHNSTONE - That is exactly right, but like I said, and to reiterate your point, Ms Forrest, there are pockets where you can have 24-hour access but it depends on what your local service looks like. We need to have consistency.

We get back, Mr Gaffney, to the gold, silver, or bronze standard. I am not going silver or bronze, just talking gold. But we cannot have gold standard if we do not have statewide consistency. If you live in Dover you should be able to access the same palliative care that you can access on Flinders Island, for example. You should have all of that information. You should have that service availability for you.

It does get back to a big education piece. I have talked a lot about professional development for our workforce, but there is a big education piece for Tasmanians, and at Palliative Care Tasmania, we provide education to about 2000 Tasmanians every year. We are a very small organisation, but we need to look collectively as a community of care, in palliative care, on how do we educate Tasmanians early.

CHAIR - It is not just Tasmanians; surely it is the GPs, it is the other health professionals they interact with?

Ms JOHNSTONE - Well it is, but if you have an empowered individual who can ask questions of their GP, who feel confident to ask questions of their GP, or their community nursing service, then that is half the battle, to be honest. It is that type of thing. You can give a person in a traumatic situation a lot of information but they will not retain it.

If we included education about palliative and end-of-life care early on, even looking at our high school students, you know, aged 14, 15 is usually about the first time that humans experience the death of a loved one. For many it is their grandparents dying of a disease like dementia. If we can look at that education piece early and normalise palliative care, normalise dying back into our culture, which it was 50 years ago, then we empower our Tasmanians to be asking questions of their health professionals. It gets back to supply and demand. If the demand is there, the supply will have to follow.

Mr GAFFNEY - Just a question you might be able to help me, Colleen. Recently, I also experienced a situation where palliative care came in and assisted. In our family, there was a very solid family unit, so, they came in, did their job, and then left, and we were there looking after Jackie. What happens in situations where there is none, or very little family or neighbourly support, and palliative care finds somebody who has none of that help or background knowledge that Ruth might have, or whatever. At what stage do they say, and where do they send the person. Do they have to go into the hospital to take up a bed? Or how is that diagnosed, I suppose, or how is that worked out?

Ms JOHNSTONE - It really depends on the situation and where people live. For example, I know of a case in the north of the state where there was a gentleman who didn't have family. The specialist palliative care service up there supported him to die at home. I also know of cases where people don't have family and their choice of death might be a palliative care unit or in their home, but that's just not possible, so they are moved into residential aged care. For many, residential aged care would never be their preference. They haven't lost legal decision-making capacity, it's just that it is the only place they can go.

CHAIR - To get 24-hour care.

Ms JOHNSTONE - To get 24-hour care. The number of cases, again, I have heard anecdotally of people who are at very end of life who have turned up to one of our key hospitals and have been referred into residential aged care, only to die within days. That's really traumatic, not just for the individual but also for our hospital staff, our palliative care service staff and our residential aged-care facility staff. It is not the ideal but that is, essentially, one of the only options available.

Mr GAFFNEY - Further to your discussion about having extra nurses available, that, in turn, would mean the person would possibly be better catered for in their own residence than going into a hospital bed or a palliative care bed?

Ms JOHNSTONE - Yes, if we have more nurses, more support workers, I feel a bit like I am saying more, more, more, but we need to get our workforce right. We need to have the clinical workforce and we also need to have that support workforce as well.

Dr SEIDEL - The Government proposed a rural health workforce unit located at the Mersey Hospital. Are you involved in workforce planning for palliative care?

Ms JOHNSTONE - The Tasmanian government, as part of their Tasmanian Palliative Care Policy Framework, has a strategy called Strengthening Communities of Care, that is a palliative care workforce project. One of the key outputs from that project that we have been involved in is the state of palliative care summary report, which was released last week. I will ensure that members of the committee receive a copy of that. That report looks at what our palliative care workforce looks like in Tasmania. It breaks it up into those four segments, it looks at the key workforce challenges across those segments. This has been provided to the Department of Health and they will use this as part of their revision of the Tasmanian Palliative Care Policy Framework and should feed into their workforce policies more generally.

Dr SEIDEL - Is this going to result in having more nurses on the ground and more people being involved or is it just another report we put on the shelf and never look at?

Ms JOHNSTONE - Palliative Care Tasmania will be actively lobbying and we have been quite successful in our lobbying. However, I am not the minister for Health, so I can't tell you what will happen.

CHAIR - If Bastian is, what would you ask him?

Ms JOHNSTONE - We would provide him with this and I would be asking for, like I said, not just that resource piece, not just funding for more nurses, more allied health professionals and more support workers. I would be asking the minister to lobby in Canberra for those pieces involving remuneration for GPs and pharmacists. We cannot get the community palliative care piece right unless the federal government looks at the MBS items and ensures that those people who work in palliative care are appropriately remunerated.

CHAIR - That wasn't the question I had here for you, that was about the various cost, potentially shifting or gaps between the Commonwealth and the state. Primary care is funded, particularly the medical professionals part-funded through Medicare or the PBS medication. I know when my Dad was dying, I went to the pharmacy and picked up all the schedule A drugs and other S4s that I needed to take to the staff at my parents' place, for them to get the syringe driver and have all the booster doses there, ready to go. The cost of that was, from memory, about $180. I had the capacity to pay. We hardly used any of it, because he died that evening. He had a death where and how he wanted. I was duty-bound to return those S8s to the pharmacy. I took all the S4s back as well. I did not get any money back. For many people in that circumstance it is financially impossible. Is that an issue here too?

Ms JOHNSTONE - It's not been reported to us as an issue. What has been reported to us from the north-west of Tasmania, not related to pharmacy, is that the families of some

palliative care patients have received invoices for the community nursing services that have been provided.

CHAIR - From the THS?

Ms JOHNSTONE - Yes.

Dr SEIDEL - Yes.

Ms JOHNSTONE - So, this does not happen across the state. In some areas there is no invoicing, but on the north-west there seems to be invoicing. That can mean that two or three months after the death of their loved one a family is receiving an invoice for $3000 or so. For many Tasmanians who are struggling that is really prohibitive.

CHAIR - If they do not know that is happening it could be quite a barrier.

Ms JOHNSTONE - It can be. That's something the Minister for Health and the Department of Health need to look into, ensuring that the cost of community nursing services for palliative patients across the state is free.

CHAIR - The medication I took back were all unopened boxes, sealed. They could have re-sold them.

Ms JOHNSTONE -I cannot answer your question, sorry.

CHAIR - I know. It was okay for me, I could afford that. For other family members it might be a huge barrier that they just cannot afford. They would have to go to the hospital where it is free.

Ms JOHNSTONE - It might be worth talking to the Pharmacy Guild, but that has not been an issue reported to us.

Mr DUIGAN - I am sorry, just to pick you up on the community nurse visits being billed. Are people made aware that they will be receiving a bill? How does it work?

Ms JOHNSTONE - It depends.

Mr DUIGAN - Why would that be different in one part of the state to another part of the state?

Ms JOHNSTONE - I cannot answer that. I do not know the reason why it is different. It is just what it has been reported to us. My assumption only is that the person who is dying may have been made aware. When they die it is their family that is left. It is the family that receives the bill. The family may not have been made aware. I have heard about it from the north-west coast. I do not know if that is happening in other areas of the state. Dr Seidel is nodding at me so he may have heard about it.

Dr SEIDEL - Yes, it is happening in the south as well.

Ms JOHNSTONE - Yes. Palliative care patients should receive free community nursing services from the THS.

Mr DUIGAN - Do the community nurses charge for other services?

Ms JOHNSTONE - They do, unless you honour like a concession card or something. If you need community nursing to do some wound care or something like that, there is a charge. When you are dying and you are at your most vulnerable, that is when we believe that you should not have to pay for THS community nursing services.

CHAIR - Is there also an argument that community nursing should be funded by the state? You are keeping these people out of the hospital. They are visited at home by the community nurse, whether it is for a dressing, removal of sutures, administration of drugs, or whatever it is, they are having it done at home rather than in the hospital.

Ms JOHNSTONE - I don't mind how community nursing is funded, I would just like community nursing to be free for our palliative care patients. When you look at the economics around palliative care, if a person is in a palliative care bed, let's us use the Whittle Ward, because we are in Hobart, KPMG estimates that cost is about $2700 per day. If a person is cared for at home, that cost is more than halved. The economics of providing palliative care at home and in the community is substantial.

CHAIR - You get charged at home but you don't get charged at the Whittle Ward?

Ms JOHNSTONE - That's right. It's a mystery.

CHAIR - It encourages people to go to the hospital.

Ms JOHNSTONE - It's a mystery to me, Ms Forrest. I was not aware that our palliative care patients were being charged for community nursing until the last couple of months when it came to my attention. If it was a consistent cost across the state, I would have known about it. Because it seems to be some in the south, some in the north-west, it's not consistent.

Mr DUIGAN - How do you delineate what's palliative care and what's not? Does the patient have to say, 'I now have entered the palliative care space'?

Ms JOHNSTONE - No, that's really up to the health professionals. When you are diagnosed with a life-limiting condition, if you were diagnosed with a condition for which there is no cure, it is palliative care. A long time ago there was a thought that palliative care was only for people who were suffering cancer. Palliative is for anyone with a life-limiting condition.

If you are diagnosed with a condition like MND, MS or other neurological diseases which you could live with for a while, even dementia - like I said, dementia is the country's second largest killer - that's a life-limiting condition. Palliative care is care and support that is aimed at neither hastening death nor prolonging life. It is about providing you with the best quality of care so you can have the best quality of life while you are living with this life-limiting condition.

Most palliative care is not provided by a palliative care service. It's provided by your next-door neighbour who does lasagne or picks the kids up from school, or your GP, or your community nursing. It is a community of support that provides predominantly palliative care. It links to the education piece. Most people out on the street don't understand this.

Ms LOVELL - It's end of life.

Ms JOHNSTONE - Yes, they think it's your last few days of life with a kindly doctor giving you nice doses of morphine and nurses helping you out a little bit in a unit.

CHAIR - It's just so far from what the reality is.

Ms JOHNSTONE - Yes.

CHAIR - Obviously there's a body of work that needs to be done about this. We are out of time. Is there anything else you wish to say that you haven't?

Ms JOHNSTONE - No. Thank you all for taking an interest and for giving me the opportunity to appear in front of you today.

CHAIR - Thank you.

Ms JOHNSTONE - Thank you.

THE WITNESS WITHDREW.

Ms CONNIE DIGOLIS, CEO, AND **Ms BREE KLERCK**, SECTOR DEVELOPMENT COORINDATOR, MENTAL HEALTH COUNCIL OF TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to our public hearing for the Rural Health inquiry. We appreciate your submission, Connie, and you appearing before the committee. This is a public hearing. It is being transcribed by Hansard and it is also being broadcast. Everything you say is covered by parliamentary privilege. That may not be the case once you leave the room. If there is anything of a confidential nature you wish to share with the committee you can make that request. We will consider that.

Do you have any questions before we start?

Ms DIGOLIS - No.

CHAIR - I invite you to introduce yourselves and speak to your submission. We will have some questions for you.

Ms DIGOLIS - I introduce Bree Klerck, our sector development coordinator.

MHCT is the peak body for community-managed mental health services in Tasmania. We represent our members and advocates for mental health system improvement to support the mental health and wellbeing of all Tasmanians. We welcome the committee's inquiry into rural health services and can provide further detail to our submission, which specifically focuses on access to suitable and timely mental health services for Tasmanians living in rural and remote areas of Tasmania.

In my statement today, I will provide the committee with an understanding of the impact of limited access to mental health services in rural areas, along with some suggestions to improve access to mental health services for all Tasmanians, particularly those Tasmanians who are living in our rural and remote communities. In January and February this year, we travelled around the state, including the islands, to hear from rural communities about their concerns and access to mental health supports and services.

In St Helens, we heard that if someone is in suicidal distress they are often taken by police or ambulance to Launceston General Hospital for assessment. However, admission to hospital isn't guaranteed and, if not admitted, the person needs to find their own way home. One community member explained that there's a saying in this town, don't have a mental health crisis between 5 p.m. Friday and 9 a.m. Monday.

Equally, on Flinders Island, we heard that if someone is in suicidal distress the air ambulance will transport them to the LGH. However, if the person isn't admitted, they will need to find their own way back to Flinders Island.

In Smithton, we heard there are not many health professionals or support workers in the area and, of those workers in the area, there's no consistency or opportunity to build relationships to support their health and recovery. We also heard that most services are in Burnie, which causes barriers due to transport.

Similarly, in Queenstown, we heard of very limited services and social supports, with most of these services being outreach only. We heard that if a person needs to access services in Burnie the cost to travel is one barrier, but they may also need to pay for overnight accommodation in order to attend that appointment. This means that access to service is simply unavailable to many who cannot afford the travel and accommodation expenses.

On King Island, we heard that there are very limited clinical options, with locums coming in, there's also inconsistency and the need for people to constantly repeat their story. Additionally, we heard there's limited understanding in the community of when services would be coming to visit the island.

These stories are just a few examples of what we heard in our consultations with rural communities. What was consistently evidenced is limited access to timely and suitable mental health services that meet the needs of the individual, whether that person needs a low level of mental health support or is in suicidal distress, and there's limited assistance to meet their needs. We also consistently heard of the frustration from locals that they don't have the skills, knowledge, experience or confidence to support a fellow community member in need. Responding safely and appropriately to someone in distress to ensure the best outcome for all involved is something they are actively seeking.

As an organisation, we represent and advocate for community-based mental health supports. We have argued that a call for more hospital beds should only ever be a last resort. The measure of a successful mental health system is one that demonstrates we're doing all we can to keep people out of hospital. To support people's recovery and needs in their community delivers better outcomes for the individual, their family and their friends. This principle should be available for every Tasmanian, regardless of where they live on the island.

Having the most dispersed population of any jurisdiction in Australia, the challenges we face in meeting the mental health needs of many Tasmanians are also felt in our urban cities. However, the impact of having next to no access to support in our regional towns is something we must look to address.

Just yesterday, we released a report on the impacts of COVID-19 on the mental health workforce, which has highlighted the workforce challenges that, to be honest, were evident before COVID-19; COVID-19 simply exacerbated them. These additional pressures are felt even more acutely in our regional towns. While part of the answer simply lies in needing more people working to provide the mental health supports, our submission and feedback to you today is also about how we need to do things differently to ensure no Tasmanian, regardless of where they live, is left behind.

We know that a limited rural mental health workforce contributes significantly to these access challenges. However, we cannot simply rely on expanding the workforce alone; we must consider new ways of addressing mental health supports in our rural and remote areas so that people can recover and live well in their communities.

This requires skilling-up rural communities in mental health literacy so that people know what good mental health is, the science of mental health decline, and when, and, most importantly, where to get help. This help should be available to all Tasmanians regardless of where they live in the state.

The Tasmanian 1800 Lifeline number funded in 2020 as a mental health response for COVID-19 is a potential starting point, providing a centralised point of information and referral to services and supports based on the individual's mental health needs. We heard many stories of people rallying to support someone in their community who was clearly in need of support but not knowing how to navigate them to the right support.

A counselling-based triage option could provide the response people need to ensure someone is professionally assessed and then guided to the appropriate level of support. We have equally heard many examples of people who, while their need is recognised, they are also often referred to the wrong level of support so this is also a potential way to address this.

This service and triage framework could offer potential for GPs, community family centres, men's sheds, neighbourhood houses to tap into on behalf or alongside someone who they recognise might benefit from some form of intervention. They don't need to have the skills and knowledge; they just need to know the number to call.

Additionally, we must also make sure we support those people who have a severe and persistent mental illness to live well in their communities and ensure that if an individual experiences an acute mental health crisis they have access to immediate support. This requires innovative thinking and a renewed look at Telehealth models that support rural health workers to connect with urban mental health specialists.

An example is the Gold Coast Health GP Liaison Psychiatry Service model which supports GPs and the care of patients with identified mental health needs through collaborative care, education and joint consultation. The service enhances the continuity of care of individuals after discharge from hospital and is a contact point for GPs with common queries regarding medication management strategies and advice on referral pathways. It provides that ongoing continuing care for someone in the community.

In supporting people experiencing an acute mental health crisis, New South Wales Health has introduced the Police Ambulance Early Access to Mental Health Assessment Via Telehealth Programming - an incredibly long name for a program.

CHAIR - Has it got an acronym?

Ms DIGOLIS - No, I checked - not one that's easy. The program equips police and paramedics with iPads to directly engage the individual with a psychiatric assessment team that is based in the hospital. An assessment is made via Telehealth and the individual either transported to hospital for admission or considered safe to stay in the community with follow-up referral to community-based supports.

Tapping into the clinical resource and assessment that isn't available in a regional town without unnecessarily removing that person from their community could make all the difference in how someone engages with the supports that will maximise their recovery. It has been offered in a way that can minimise additional distress, especially if there are options that will allow them to stay at home in community and it's for them and for their family.

Ms LOVELL - Connie, where was that one?

Ms DIGOLIS - New South Wales.

Ms LOVELL - Thank you.

Ms DIGOLIS - These models are examples of how other states are addressing similar rural mental health challenges. We suggest that a national scan is undertaken of rural mental health programs with consideration on how these programs could be effectively adapted to suit rural Tasmanian communities and to explore ways of bringing the service or the support to the person rather than the other way around.

On a final note, Tasmania's mental health plan Rethink 2020 commits the state and federal government to work together to ensure that mental health care is accessible to all who need it at the right time and in the right place for the person, regardless of where they live in Tasmania. It's evident through our consultations that rural communities are disadvantaged in access to timely and suitable mental health services. Without access to these supports we're leaving our rural communities behind.

In implementing Rethink 2020 we must ensure that equal priority is given to improve the mental health system, not only for our urban areas but also for our rural and remote communities so that all Tasmanians can recover and live well in their communities. Thank you for your time today. I'm happy to take any questions.

CHAIR - Did Bree want to say anything in addition?

Ms KLERCK - I think Connie's summed up our -

Ms DIGOLIS - She will help with some questions.

Dr SEIDEL - I might start. I'm going to be quite specific. It's about workforce and medical workforce. You talked in your submission about the role of GPs and the accessibility issues there. You also said that GPs can be trained in focus psychological interventions and so forth. You said cost is an issue and that you would like to see mental health consultations being bulk-billed, mental health cap plans being bulk-billed. Is there a role for the state Government to subsidise those services to ensure people see their GPs as one of the primary care points?

Ms DIGOLIS - That's a great question because we would normally say that that would be an MBS issue and then that becomes federal government responsibility. Did you want to touch on that at all, Bree?

Ms KLERCK - I do think there is space. I think the issue is the access. First, it's accessing a GP and then accessing a psychologist. What we are hearing in the north-west and the north is there is a limited number of psychologists. First, it's seeing how we can get that workforce into the community and if there is scope for the state to subsidise some of those costs. I think also it's the travel. If somebody living in Queenstown has to travel to Burnie to access a psychologist or supports like that, then there's the cost of the travel. If it is late in the day then they will need to stay overnight. Those costs inhibit people from accessing mental health services.

Dr SEIDEL - There are some pathways for medical practitioners to be rural generalists with a subset of specialty skills, often in emergency medicine or minor surgery or obstetrics gynaecology, but there probably should also be a focus on mental health. Is that something

you've considered at the Mental Health Council, whether a rural generalist should have mental health as one of their pathways?

Ms DIGOLIS - It is something that we have discussed with government agencies. PHN is a wonderful avenue towards to GPs. It's probably not moved past an idea. A lot of that has been determined around the appetite for GPs and how we might be able to engage them with that. There seems to be a great variety of interest. That's where we have been looking at things like the individual assessment referral process and whether, as Bree has suggested, we might be able to build connections between the clinical specialised support and a GP via an assessment process, which would help a GP understand the level of care that somebody might need. That could be accessible to GPs or they could tap into something like a phone service that can do triage on their behalf, even when the patient is sitting with them.

Regarding your question, we are seeing an adverse impact on people in rural towns in accessing the supports, which can be cost prohibitive. The question is whether that should be a state responsibility because it is about meeting the level of disadvantage due to where they live. There is a good question about enabling GPs to be able to provide that specialised care in their communities. We are not entirely clear on the appetite for that but who's to say what we might be able to achieve with a more targeted approach.

Ms KLERCK - There's low hanging fruit, easier ways with the IR framework and a centralised phone number where GPs can call and access information and referral support initially. That is a helpful way to address that problem in the interim while they're looking at more specialised training.

Ms DIGOLIS - From a Commonwealth perspective it would be fair to say that there are assumptions that if your GP organises a mental health plan for you then there is psychiatric support you should be able to access. In Tasmania, in our urban areas but most certainly in our regional areas, that access isn't there for them,

CHAIR - If I can follow up with a couple, Bastian?

Dr SEIDEL - Yes, sure.

CHAIR - A few things you have touched on. The need to travel. The Patient Travel Assistance Scheme supports patients having to travel for psychology or other medical appointments related to mental health.

Ms DIGOLIS - The examples we've drawn from have been with people who are in a mental health crisis or even in suicidal distress. They're being taken to the hospital as their first point of contact to be assessed, often on the understanding that they will be admitted. For many people in suicidal distress, admission to a mental health ward isn't the best option for them.

CHAIR - Neither is tossing them out onto the street to find their own way home.

Ms DIGOLIS - No. We heard from some people that the ambulance transport option isn't an option for them, either, so it was the additional distress for a family member or friend to transport them to the hospitals, which might be a four- or five-hour return trip.

CHAIR - In that case, does PTAS cover that travel?

Ms DIGOLIS - I don't think it does, unless they have a diagnosis. In the examples we heard the most about, it was about getting that initial assessment and potential admission and that was only available via an urban hospital, especially if we we're talking after hours or weekends. Often, a GP wasn't available. They may call a CATT team or the Mental Health Service and the next point of contact for them is an urban hospital.

Dr SEIDEL - When you've been out in the community in rural areas, have you heard that there are delays for CATT teams to come out?

Ms DIGOLIS - Yes.

Dr SEIDEL - How substantial are those delays?

Ms DIGOLIS - It can depend on where the person is based. It can also depend on what the demands are for the CATT team at any given time.

Dr SEIDEL - What would you think is an acceptable time frame for a CATT team to attend?

Ms DIGOLIS - I don't have a clinical background, Bastian, and I imagine it would be dependent on the specific situation. Any delay isn't ideal for somebody who is potentially becoming increasingly unwell and distressed and may be at risk of harming themselves. Again, that relates to how we might be able to link people in to urban clinical support to determine the best way to address the needs for the person, but also to potentially help de-escalate the situation until care arrives.

Dr SEIDEL - Would you think the same day is a reasonable assumption to have access to a CATT team when somebody is in acute mental distress?

Ms DIGOLIS - On behalf of any family member or friend, you wouldn't want to be waiting with somebody while they are becoming increasingly distressed for more than a matter of hours.

CHAIR - We put waiting time expectations on ambulances. Ambulances are called for people in distress, maybe mental distress but physical distress. Why is it different? Is it different? Should we expect the CATT team to arrive in a similar time frame as an ambulance would?

Ms DIGOLIS - That's probably the original design of the CATT team model, to provide that kind of response. It would be fair to ask whether that's possible with the resources there at the moment, or whether it's even sustainable or practical. We are seeing a significant restructure of the public mental health service. That is in response to trying to determine a better way to provide the services in a more timely way.

CHAIR - Thanks. Obviously, COVID-19 has had a significant impact. Thankfully not quite to the same degree in Tasmania as it will have had in Melbourne and Sydney. There are some Tasmanians who are quite anxious about 15 December for many reasons, not just because of their mental wellness but other physical concerns as well. We've heard from TANA, which is looking at trauma-informed care. I don't know whether you've had much to do with TANA,

but what do you believe about the level of trauma-informed care and awareness in our health workforce generally, and particularly those who are responding to people in mental health crises, with our worsening mental health conditions.

Ms DIGOLIS - We are seeing significant moves being made within public mental health services to implement trauma-informed practice across all levels of care. It would be fair to say that the community service sector speaks similarly. There is certainly a lot of research which supports that; it could be appropriate knowledge, understanding and experience for any service to be able to employ that kind of response to people who are presenting to their services.

We don't have a consistent approach yet across community support services, but I am sure that if we were to look at ways to improve access to that professional development and learning, we would actually see that taken up quite strongly.

CHAIR - If there was a more consistent trauma-informed approach to people with mental health challenges, do you think this might help to keep people out of our acute system more? You still need to have the services in the community, I appreciate that, but do you think that would have a significant impact?

Ms DIGOLIS - Absolutely. I think we can see a lot of examples. Again, a lot of research points towards trauma-informed care making a difference to how the person is actually going to respond, and then be able to calm, and to those assessments to come into train. As I said, for many people in suicidal distress, admission to hospital isn't the best option for them, so this would support that kind of approach.

CHAIR - In terms of helping more of our health workforce and frontline response to be more trauma informed, whose responsibility is that - in terms of that professional development, additional training? Where do you see that fits?

Ms DIGOLIS - We think that is something that probably needs to come into the joint workforce development strategy, which is sitting in rethink for next year. We can't look at growing the workforce without looking at upskilling the workforce, and looking at all of those areas that need to be looked at to ensure we are providing contemporary best practice care across all levels of services.

In our submission we do talk to some additional work around prevention and early intervention, and some of the mental health literacy work that needs to happen in our broader population to help people understand how to recognise when somebody might be becoming unwell, and how to intervene earlier, before it has become a situation that might be dire. There is also work we need to do in communities as well on that question.

CHAIR - A community informed about trauma would be beneficial broadly, not just to the health workforce.

Ms DIGOLIS - Yes, absolutely, especially as we start looking towards the community service workforce, to some of those community organisations like men's sheds, neighbourhood houses, family centres - those touchpoints for people who may have community members coming into their services who may not be doing as well as they can.

CHAIR - Alluding to a comment you made earlier about doing things differently, what would doing things differently look like in Tasmania, in terms of getting the best outcomes for the people and families you represent, particularly from the rural sector - if you could say blue sky stuff, don't worry about the dollars?

Ms DIGOLIS - I think we need to look at both a place-based and then a more strategic systems-based approach. Place-based is looking at the basic skills, almost setting that benchmark for the essential skills and experience and responses that we need within those communities; that can include the community members understanding more about mental health and the importance of doing something sooner. Then we need to look at the systems-based approach - how we can integrate services, and integrate our urban and rural areas together, so they are actually ensuring people in a more remote community are getting access to exactly the same level of care as somebody in an urban area. I guess we've tried to suggest that some of that is about how we make those remote connections.

There's another argument that if the work is in the community, why don't we make sure we're running grad programs and that we're looking at upskilling a workforce that might stay in those rural communities. That's probably a much longer-term strategy than something that might be as 'simple' as ensuring that people in the community have the iPads and have the connection directly to those clinical supports that are sitting at the hospital and there are ways for them to connect at any hour.

CHAIR - What I'm hearing, Connie - correct me if I'm wrong - is a very local approach to local need. Some of our communities have a much higher proportion of older people who may have issues with older persons' mental health. Some may have a much younger population with a range of other challenges. Do we need to have more individualised approaches within those communities? It's not one size fits all?

Ms DIGOLIS - I don't think it can be one size fits all. Along with a dispersed population, we have a very diverse population when it comes to the differences between many of our communities. That became very apparent to us when we were probably naively thinking we were going to see similar themes within the regions.

We saw, especially in the north-west, quite different themes coming out from different towns, depending on which part of that actual region we were in. Even grouping our three regions isn't doing those communities justice. Yes, I would say it absolutely is place-based, which becomes very much around how we can look at that scale of economy to a workforce that's spread thinly anyway, but also to ensuring that we're actually looking at ways to provide those linkages in a way that's sustainable.

Dr SEIDEL - I will stay with workforce upskilling for a bit, because it has been raised by other peak bodies and advocacy organisations. How realistic is it to achieve in rural areas, where the service provider is already very busy, close to burnout, and the solution is, 'let's do some upskilling here'? Because the vast majority might not be able to say, let's take some time off here because I have nothing else to do anyway.

How do you really do it? Is it an issue if we go to an already at-capacity workforce and tell them, now is the time for some upskilling here? Are those people checking out completely, saying we've had it, we don't want to hear about upskilling, education anymore. Is there a risk when we put more demands on existing health service providers?

Ms DIGOLIS - It's a really great question. It's one I feel I can answer more easily when we're looking at some of those lower mental health interventions and supports, because across the board over the last couple of years we've heard intense interest from other community services to actually be able to respond to the people who come to their services.

Neighbourhood Houses would be a good example; family health centres are another example. Youth centres have been talking a lot about it over the last year. Their main business isn't providing a mental health support; their main business is actually caring for the supports of the individuals and the young people that come to their service. But in doing that, they recognise that those individuals have mental health needs, and they want to be able to respond to that, and to understand the best way to do that and to support that person to access supports - which may not be clinical; they may be non-clinical supports.

There is an interest outside of the mental health and health sector generally to actually be able to understand and be part of that; it's almost a gatekeeping approach for many people, because they're the point of contact for people.

I think we see that more strongly in our regional towns, because there isn't that separation of those - and the broader access to those other health supports which we may rely on more in urban areas.

Ms KLERCK - I agree with Connie. Those services that sit outside of health and mental health would like to be upskilled, and we've heard that - and that's around that lower intensity mental health literacy.

But I do think if more of the rural health workforce had access to a centralised intake service, or a phone number where they don't need to have the specialised skills - they can ring that phone number and find out what mental health supports are needed for their patient - that would be beneficial, and an easier way to do things at this point in time.

Dr SEIDEL - So the services that you mentioned are often, or the level you mentioned is often respond and refer, but eventually it is going to be closing the care abyss as well, ideally, as local as possible. So, that is the entity I was more referring to. How do we support the services that are there to close the care where we are wrapping things up for the person?

Ms KLERCK - I think it is ongoing. We want people with severe and persistent mental illness to live in their communities and locally in that community. Potentially it is about some of those examples of the Gold Coast Health Service where you are linking psychiatrists and specialists, who are perhaps sitting in urban areas, with the rural GPs. They have this constant communication and the GPs have access to a psychiatrist to get that support about medication and what to do next.

Ms DIGOLIS - I think, looking at those more integrated approaches to continuing care.

Dr SEIDEL - We do not really have that in Tasmania, though, where there is a dedicated, for example, psychiatrist responsible for Flinders Island, or Huon Valley, Bruny, the channel. It does not exist, does it? It is not dissimilar to what is happening in the UK, for example, where we have those intake teams responsible for certain areas.

Ms DIGOLIS - One of the inherent challenges with our health system is that we are very good at discharging people from a point of care. This is potentially about how we look, most specifically for people who live in remote areas, how we look at adjusting that definition of discharge, and instead looking at what that continuing care actually needs to look like, and how we actually provide it.

Understanding that we would also be looking at things like psychosocial supports as well. We know that the NDIS market is incredibly thin, if completely non-existent, in many of our rural and remote towns. That is not about building a health workforce, it is about building a psychosocial support workforce. That is not something that we have necessarily touched on in our submission but that is certainly is another challenge for people who are living in our rural areas.

Mr GAFFNEY - I am very interested talking about preventative health measures, and you recognise that sometimes we are reactive in what we do. In my area, the Burnie north-west area, the burnout of youth workers and the lack of support and the thing I find there is that in the teaching profession, if you want to have a different place to work, after three or four years, you apply for a different school or whatever. I do not see that support with a person who might be the only youth worker in an area. Suddenly, that youth worker becomes ill, or worn out. What support are you able to give trained professionals who need a break, or before they become ill?

I would like you to make a comment if you could on - the colleges worry me, with 17- and 18-year-olds. They have 1.7 social workers for 700 students. We all know that 17- and 18-year-olds are particularly volatile in their emotional patterns sometimes, depending on what is happening around them. Some of the stories you hear where there is no service available, and so they spiral. Do you have any comment about where you feel the education system can link in with some of the support networks you have? The first one is about burning out the people we have working in the industry.

Ms DIGOLIS - I will try the workforce one, and I believe we do have a copy of our workforce impacts report here, which also talks towards the support that we actually need for the workforce more generally. We did some work earlier this year with some youth roundtables and some consultations with all youth service providers in each region. One of the things that they talk about was wanting to look at how they can actually come together and network more effectively together. We need to find ways to be able to encourage that.

Something that has not been explored is looking at sharing positions and seconding, and looking at, because I think it would be fair to say that, the public mental health workforce also has similar strains and stresses as well. We have also talked about it, in terms of workforce shortages. How we look at a dedicated position or role may actually be sitting in two or three different services, but they might be primary, community and public. That's a way for somebody perhaps to be able to have some job variety which may also work.

These things haven't been explored but they have certainly been flagged. It is something that we have been talking about with government agencies, how we need to build that into that workforce strategy over the next few years which is going to be about workforce wellbeing, no question. There will be examples where we can find some good models to look at and see how they could be implemented here.

The question of 17- and 18-year-olds is really interesting. We can see that there is a lot of policy commitment towards creating better positions and access to those supports in schools. We have also advocated for programs that are looking at peer support programs and ways for younger people to support each other, understanding that when they are 17, 18, they will often use their own social and peer networks to reach out to, often more than they will the school or the family environment. We have been advocating for a number of years about what we could be doing and would like to be doing to build up young people to be able to look out for themselves and for each other as well.

It is a staffing issue and it would be fair to say that while we talk about the workforce challenges, Tasmania isn't alone. This is national and international when it comes to health professionals and that we are looking at creating those positions in education as well, provides an additional challenge with where we will find them.

CHAIR - You talked about a national scan of rural health and mental health workforce. Did you say that is actually being done or it needs to be done?

Ms DIGOLIS - It was what we think needs to be done in order for us to see where all those little clever innovative ideas are around Australia. We have talked about two examples but there would be more examples and how we can actually look at how they can be 'Tasmanianised', if that's the right word to use.

CHAIR - I assume it's operating in and around the greater Sydney area but New South Wales has some remote areas too. Is that model used in the remote areas or is it just mainly in the urban area, do you know?

Ms DIGOLIS - I think they are continuing to use it in the Port Stephens area. That is quite rural in terms of how far it is away from Newcastle, which is more of a hub about an hour and a half, two hours out from Newcastle.

CHAIR - What's the population of Port Stephens?

Ms DIGOLIS - I wouldn't know.

CHAIR - It would still be bigger than most of our towns.

Ms KLERCK - Yes, it probably is.

Ms DIGOLIS - I assume it would be, yes.

CHAIR - I am interested in whether you have looked in some of Queensland. Some of the more outback tracts in Queensland or Western Australia.

Ms KLERCK - That would be interesting to do.

Ms DIGOLIS - That's really what we need to be able to do.

CHAIR - For someone to do that, is that something that you would have the capacity to do? With funding, I assume, you would need to actually facilitate that. Or is there someone else who should be doing that work?

Ms DIGOLIS - I think that we would be able to probably form some fairly strong partnerships with some national rural mental health organisations and be able to work with them to identify where the work is and then, as I say, the skill for us dealing with our unique little island is that we need to look at what actually suits Tasmania. We haven't got the vast distances and we are dispersed but we have got the very small pockets of people. As I said, we have that variety across those communities that can actually be evident, even though it is in a fairly small geographic region. It's about how we can look at making it suitable and bringing it back to those towns and saying, what suits you as a community? How do we make this work and how do we bring the system to you rather than you having to go to the system? Historically that is what they have had to do.

CHAIR - Yes, that's the key isn't it, in many respects.

Ms DIGOLIS - It's about staying in the community, especially for somebody who is experiencing mental distress as much as mental illness. It's the fact that the option for them at the moment is to be completely removed from their home, from their community, from their family and their friends.

CHAIR - It is probably more an issue potentially for our indigenous people too, I imagine?

Ms DIGOLIS - Yes, absolutely.

CHAIR - To be taken away from their family and their support.

Ms DIGOLIS - That comes back to your comment about trauma-informed care and we could say the same for the Tasman as well. We can't forget the history and that that is part of what can sit generationally with many communities.

CHAIR - Yes. Thank you very much, Connie and Bree, for your submission and the evidence today. There's nothing you feel you haven't said that you have wanted to say before we finish up?

Ms DIGOLIS - No, I hope that we haven't glossed over it. As Bree pointed out, there is some low-hanging fruit. There are some things that we could do and that we could do now but we still need to keep our eye on the horizon and look at those longer-term needs.

CHAIR - What are the key things that we could do now that aren't being done?

Ms DIGOLIS - We could be looking at that integration with urban centres. How do we tap into that, those clinical supports? We could look at improving pathways for GPs and for other community service providers in those communities to know how they can link in with potentially having someone triaged or assessed or just knowing where those services are that they can access almost at any time. I think we need to skill up our people in communities to understand that this isn't about waiting until you are so unwell and you do your annual visit to the GP. This is about something that needs to be a day-to-day thing for them.

CHAIR - Thanks for that.

THE WITNESSES WITHDREW.

The Committee suspended from 12.17 p.m. to 1.02 p.m.

Mr JEREMY ROCKLIFF, MINISTER FOR HEALTH, WAS CALLED AND EXAMINED.

Ms KATHRINE MORGAN-WICKS, SECRETARY, **Ms MICHELLE SEARLE**, ACTING DEPUTY SECRETARY, POLICY, PURCHASING, PERFORMANCE AND REFORM; **Mr DALE WEBSTER,** DEPUTY SECRETARY, COMMUNITY, MENTAL HEALTH AND WELLBEING, DEPARTMENT OF HEALTH, **Prof ANTHONY LAWLER**, CHIEF MEDICAL OFFICER AND DEPUTY SECRETARY CLINICAL QUALITY, REGULATION AND ACCREDITATION, DEPARTMENT OF HEALTH, **Mr JOE ACKER**, CHIEF EXECUTIVE, AMBULANCE TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome, minister, to our hearing for the Rural Health inquiry. I appreciate you bringing all your team, of which there are many. This is a public hearing. Everything you say here today is covered by parliamentary privilege but that may not extend to outside the room. If there is anything of a confidential nature you wish to pass on to the committee, you can make that request and we will consider it. We are being broadcast and it is being recorded.

I will ask you to introduce members of your team and to make some opening comments before we get into some questions.

Mr ROCKLIFF - The introductions will be done by the individuals themselves but we also have Angela Downie, Nursing Director, Primary Health, North-West and Bruce Edwards, Primary Community Services in the south who also may answer questions.

CHAIR - If they come to the table we'll get them to swear before they give any evidence.

Mr ROCKLIFF - I have a reasonably shortish opening statement, if that's okay. I have a copy with me, which is the submission of 12 August 2021 which you have and no doubt will cover. Thank you for the opportunity to participate in the inquiry. I am sure there will be very positive outcomes from it. I have heard a number of stakeholders already and been briefed on a number of their presentations as well and I have no doubt the views shared through the process will contribute to the future planning and delivery of services, notwithstanding our clinical services planning that is ongoing at this present time. I look forward to receiving the final report from the committee.

Clearly, we are committed to building a sustainable health system right across the state, whether that be the larger areas of our four major hospitals, and indeed the primary and health care throughout our communities, of course.

While delivering on that commitment, we are also investing significant time and resources on our COVID-19 preparedness and preparing our health system for when our borders reopen on 15 December, and as part of rural and regional health care, one of the changes that we have seen that could be positive as a result of the pandemic - and there are very few - is the increased use of telehealth. Over the past 18 months, I am advised that the use of telehealth and virtual care across the Tasmanian health service has resulted in 10.8 million kilometres and 6214 days of travel time saved for patients, which is a great outcome for people living in our rural and regional communities.

In terms of our Government's commitment and the measures that we have committed to improve health services and facilities in rural and remote areas, including additional staffing and infrastructure and equipment upgrades, we have also announced several statewide initiatives relating to enhanced community care and after-hours services that will benefit Tasmanians living in rural and remote areas. I will list them briefly -

- $27.5 million for community-based health care, including hospital-in-the home services, and health care delivered in the home or community
- $18.3 million to increase staffing in Tasmania's district hospitals as part of the safe staffing model
- over $9.4 million for ill-health prevention and community-based wellbeing programs
- $1.4 million for community transport services to support Tasmanians to access care
- $5 million to deliver an additional 20 000 dental appointments across the state
- $4.5 million for the new community health and wellbeing networks in Ulverstone, Huonville and Scottsdale.

We have spoken in other forums around paramedics as well, including our commitment for -

- 48 paramedics across the state
- increased aeromedical support to our regional areas, with helipads on the east coast at St Helens and another in Dover
- a long-term strategic partnership with the Royal Flying Doctors Service to support the delivery of health services in remote and rural areas of Tasmania
- $4.3 million to establish the new rural medical workforce centre at the Mersey, to support the recruitment and retention of permanent doctors in the region
- investing in a GP after-hours support initiative to make it easier for Tasmanians to access medical care after closing and closer to home.

This will complement our Community Rapid Response Service (ComRRS), secondary triage, along with our $1 million hospital avoidance program.

We have mentioned those in other forums as well, including Budget Estimates and the Public Accounts Committee, as I recall.

We are also investing just over $8 million in staffing and equipment for our rural hospitals. This new funding is in addition to over $24 million towards rural and regional hospital and ambulance upgrades already underway or delivered at more than 40 facilities around the state.

I will conclude very shortly, but I was very pleased to be on King Island recently with the opening up of the new hospital there.

CHAIR - I'm sorry I wasn't there. I didn't get an invite.

Mr ROCKLIFF - I am sorry about that. I commend all the team there, particularly the local team that had a lot of input into that facility.

I can talk also about mental health in rural and remote areas as well. We are providing $26 million for better mental health services, a hospital-in-the-home pilot in the north-west, and just over $2 million over two years to boost community mental health services to meet increasing demand. We are continuing to expand our services established through COVID-19, including the 1800 A Tasmanian Lifeline, the Mental Health Council of Tasmania's #checkin website, and regional coordinators and community engagers increasing the capacity of Rural Alive and Well.

More recently, I was in Smithton to launch the new $300 000 locally based mental health specialist for that region - Circular Head - for counselling and outreach, as well as suicide awareness and prevention with a focus on our young people.

Our commitments to a brand-new Spencer Clinic in the north-west and our Healthcare Future reforms are all included and perhaps can come up in those discussions as well. Thank you, Chair.

CHAIR - Thanks minister. If I can just take you to page 13 of your submission, which talks about increase in demand for health services. I think we all acknowledge that there is an increase in demand. You've made the comment at 1.3.1, at the bottom of that paragraph, that part of this process will be looking at how we maximise and enhance existing services in the community such as district hospitals, recognising their key role in Tasmania's health system, providing care in rural communities.

In your opening statement you talked about the funding and staffing of rural hospitals. Can you give us more specific information about how that's rolling out, what the plan is? I believe there is probably still under-utilisation of these facilities, so how are you going to actually maximise the use of those? We did hear around the regions that there are certain barriers to use. I would be interested in your thoughts on that.

Mr ROCKLIFF - First, in line with your thinking as well, we want to have an increasing role for our rural and district hospitals, which is why we have brought forward investment, and why we have engaged with the safe staffing model in the hospitals, and why we are ensuring that equipment and infrastructure fund, as well as being mindful - at least anecdotally - of the impact potentially on our adventure tourism and other matters. I heard that in Queenstown more recently. I have had feedback in the north-east around what I perceived as anecdotal evidence of an increase in access to services needed in those regions as a result of that. I am interested in hearing more about what the barriers might be.

CHAIR - A lot of it is skill mix, interconnection with the GPs and the medical practices in the regions, and that sort of thing. Ideally, as I think you've said, you want to see them better utilised, but the occupancy rates aren't moving - unless you can show us evidence that the occupancy rates are improving.

Mr ROCKLIFF - I do have occupancy rates and separations which might be of interest to the committee. I mentioned the north-east. For example, Scottsdale hospital, in terms of separations, if I recall, some of those figures in the last four years have gone from around the mid-500s to up to over 700 in the last 12 months, which would indicate an increased activity. The occupancy of Scottsdale, if memory serves me correctly, was around 44 per cent. We can get some of those figures for you, because we have some quite detailed figures on occupancy and separations. I can go through all these and cover -

CHAIR - Are you able to table that?

Dr SEIDEL - It's in your submission.

CHAIR - All of that? No, has it changed, though? This was given to us a while ago.

Mr ROCKLIFF - Well, 12 August - if I can just look at to see what these -

CHAIR - I understand that there has been greater investment. You've talked about the additional funding you've put into this area.

Mr ROCKLIFF - Yes.

CHAIR - Has that actually resulted in more nursing staff being employed, and thus more patients utilising it? That may be the same information you have.

Mr ROCKLIFF - We can get the staff numbers that as well. Yes, I was correct, 44 per cent in the North West Hospital. They're the 2020-21 figures. There were 706 separations this financial year in line with what I said as an example. We can endeavour to get updated figures for you. Regarding a safe staffing model and access and flow and how we're utilising our district hospitals to take pressure off our four major hospitals, Kathy do you have more information on that?

Ms MORGAN-WICKS - Yes.

CHAIR - And dealing with the skill mix. Recruitment seems to be one of the challenges.

Ms MORGAN-WICKS - In 2018 we formed a committee on safe staffing, working in particular between our district hospital, nursing leads, both our major hospitals together with the ANMF to look at a variety of things about the skill mix in our district hospitals. The minister mentioned the occupancy rates which have traditionally been quite a challenge for us with our district hospitals which maintain quite a variety of occupancy rates.

We have tried to look at the safe staffing model from the perspective of safety for staff who may, with a call to an overnight emergency response issue, take a registered nurse or enrolled nurse away from the care of remaining patients in the facility. We looked at the safety, staffing and skill mix to care for the number of patients, but to also try to expand the use of our district hospital beds to alleviate some access and flow issues we experience in our major hospitals.

For example, we have piloted transfers between the LGH and Deloraine quite successfully, noting that it's not just about the safe staffing mix for nurse resources but also allied health and the specialist-in-reach support that would need to be provided by major hospitals to make sure we have the continuation of care for patients transferred to the districts.

A safe staffing model is still under implementation. We piloted and had the original funding approved in late 2020. It is underway. We have experienced some challenges in staff recruitment to staff. If we need some further detail on that I could request through the minister that Angela Downie or Bruce Edwards, who are our operational managers for the district hospitals, provide that information or otherwise -

CHAIR - The model commenced on a 12-month trial at the end of June 2021, so it has only just commenced, has it?

Ms MORGAN-WICKS - Permanent funding was confirmed through the last Budget process, but pilot funding was available prior to that by the department.

Dr SEIDEL - Can I follow up specifically on that? Looking at the table you provide on page 34 of your submission, the occupancy rate of 27 per cent at St Helens, St Marys 37 per cent, Queenstown 37 per cent. Are you saying the rates are low because you don't have the staff to look after more patients?

Ms MORGAN-WICKS - It's a combination of factors, but we need to ensure there is safe staffing to increase the number of patients admitted to these hospitals.

Dr SEIDEL - I think the data hasn't really changed over years. Do you have an idea for each area whether there are specific challenges to attract staff to ensure they can look after patients in those inpatient beds?

Mr ROCKLIFF - Tony, would you like to follow on.

Prof. LAWLER - I think we are seeing in Tasmania, as we see in many parts of the country, that there are multiple reasons why district hospitals are not being used as fully as they might be. There are some local issues such as staffing models. The safe staffing discussions that have occurred are currently in a recruitment phase and that will see at least one of those impediments to more effective utilisation of local services.

There are barriers centrally present to the utilisation of that service. By centrally present I mean in the larger hospitals that promote the more effective utilisation of those district facilities. Under the statewide access and patient flow program there are pieces of work that occur both in the larger hospitals and in the smaller hospitals but also in terms of the interface between them. In the north we have a 12-month MPA-funded project that will improve the pathways of subacute patients into district hospitals that will identify the barriers that exist and address those.

On a statewide basis we are looking through a scoping project to determine and define specific district hospital access and patient flow challenges, barriers and enablers which will enable us to identify immediate service improvements and also elements that will provide a potential short- to mid-term projects. The medical end-reach model from the Launceston

General to the local hospitals that provides specialist service, in addition to bolstering nursing resources, will provide on-the-ground medical assistance as well.

Dr SEIDEL - Thank you. Can I ask you what is your desired occupancy rate for the district hospitals listed in your submission? What's your target? What do you want to see?

Mr ROCKLIFF - We provided 2019-20 figures in the submission and we have 2020- 21 figures in front of me, Chair. Perhaps we can table them?

CHAIR - Yes, table that and then you can go to the question.

Dr SEIDEL - So the question is, once you have established what your desired occupancy rate is, can you confirm that you have enough staff, including nursing staff, to ensure patients can be looked after safely in those hospitals?

Mr ROCKLIFF - So once the figure is established? Once we get to a certain point can you confirm?

Dr SEIDEL - Yes, do you have a figure? Is it 50 per cent desired or is it 75 per cent desired occupancy rate? Is it 100 per cent?

Mr ROCKLIFF - The utilisation would want to ensure that the hospitals are there supporting the community to the best capacity possible.

Dr SEIDEL - What's the best capacity, minister?

Mr ROCKLIFF - Responding to community need where we can care for people locally in a safe environment. If they require more acute care then the best place for them would be in one of our major centres.

Ms LOVELL - Can I just follow up on that? Minister, has there been an assessment done in any of those communities about what the need might be for those local communities?

Mr ROCKLIFF - Yes. That assessment is essentially being undertaken at this present time, Ms Lovell, because we are doing clinical service planning across the state in each region, the north west, the north and the south. That will form a statewide clinical services plan. Separate to that, there is clinical services planning in statewide mental health services, which will also go into a statewide clinical services plan. Once that clinical services plan work is completed - the regional planning should be underway and completed towards the end of 2022 - then we will have greater sight of what is needed in each region. The needs of each region may change over time, not only infrastructure but service delivery given the change in circumstances within regions.

Take King Island as an example, which will hopefully have a new mine established in more recent times, so that would mean we need to support that community. On our west coast, north east in terms of adventure tourism and the like.

CHAIR - Can I take you to the west coast for a minute. We know that those bike tracks have just been opened and they're pretty fearsome ones. I won't be riding down them. The occupancy rate for 2019-20 was 37 per cent. Does the Queenstown Hospital currently have

capacity to actually increase that occupancy - this is their sub-acute beds, not their aged care beds we are talking - with the current staffing model? Do we need to engage more nurses, more other medical staff to care for patients in a sub-acute admission?

Some of these people who are injured may well require more acute services, let's hope they don't, but 37 per cent is a pretty low occupancy. I agree it could change with demand. But if that was the case, what capacity is there in that hospital at the moment and what would you need to do to increase it?

Ms MORGAN-WICKS - May I make a comment? It really does come down to the role of delineation framework and the safe provision of care in any particular institution in their geographic location. We could talk about occupancy levels but we also need to make sure that it is focused on the safe provision of care within those institutions depending on the type of injury or the medical situation that is presenting in these particular regional areas and the clinician's determination as the appropriate location for that care. Perhaps if Professor Lawler could comment on that role delineation framework and the role of our district hospitals within that framework.

Prof LAWLER - There is an important consideration to make about our district hospitals and that is that they do provide a crucial service for the local community but they are also an integral part of our statewide hospital system and health system architecture. To the question of what maximum occupancy is, we would be looking to maintain an occupancy in those facilities that best supplies care to the most Tasmanians that we can.

Partly that's about responding to acute situations locally, whether that's mountain bike related or industrial, agricultural or chronic disease and having an appropriate level of escalation care, as and when required. That's when we would call upon transport or retrieval services. As has been discussed through the statewide access and patient flow program, we would be looking to have as many patients who can be appropriately cared outside of our large acute centres closer to home as we possibly can, recognising that there are some restrictions and impediments to that that don't go to resourcing. They go to issues such as clinician practice, patient preference, family preference and we are working through those.

It is important to note that the optimal occupancy for those facilities is the occupancy that enables us to provide care to the local community but also maximise the utilisation of our high-level resources. As the secretary as mentioned, that's in line with both the role delineation framework but also the one health system intention, which is to provide care to individuals as close to home as they can but to bring them into larger acute centres if required.

CHAIR - How often is a review done of all the inpatients in our acute system, letting you know that people from the west coast go to the Royal as well as they do to the North West Regional. How many are actually there who potentially could be cared for if there were staff available to care for them?

Prof LAWLER - On a daily basis. Our hospital integrated operation centres and our patient flow mangers are continually looking at patients and where and how they might be transferred to other centres. Many of them have been receiving care of a highly acute nature within our larger hospitals and need to stay there but for some there are social or family reasons why they can't be going out into other centres. We know that there are particular hospitals where we are utilising those services quite well and are able to transfer patients.

The work of the Safe Staffing model, coupled with the work that is being done under the Health Workforce 2040 program, will give a very clear indication. The recruitment to the Safe Staffing model will improve our capacity to utilise the district hospitals but again, it does come down to having the right patients to be in those services.

Mr ROCKLIFF - This clinical services planning is an essential piece of work and there has not been a clinical services plan for some time statewide. I think the last statewide was in 2007. When it comes to health care, when it comes to increasing demand, when it comes to challenges for the recruitment and retention, we need that clinical service planning, that analysis, to drive evidence-based decision-making so we can match the needs of the community, understanding that, of course, that can change over time. It will be evidence driven when it comes to delivering what are increasingly challenging times in recruitment, retention and increases in demand for services as well.

Dr SEIDEL - If we go back to the list from 2019-20 when you have Campbell Town, where the occupancy rate is 114 per cent and you talk about the needs of the community, are you then thinking of putting more beds into the Campbell Town hospital? If you look at St Marys where you have 37 per cent or St Helens, 27 per cent, are you looking at withdrawing beds from that hospital or do you adjust the staff numbers? Do you take nurses away, do you put more nurses into Campbell Town? How does that work when you are talking about meeting the needs of the community?

Mr ROCKLIFF - First, the latest Campbell Town figures that I have are 75 per cent, Dr Seidel, and 114 per cent, you are correct, in 2019-20. I recently visited Campbell Town District Hospital, also Oatlands. We will be at St Helens and St Marys next week to talk with staff and get a better understanding of their service to the community. Perhaps as I have discussed with staff and management responsible for district hospitals, the various needs of the community as well and Campbell Town is an example of that. In terms of assessing the needs, and Professor Lawler might want to comment on this, you are not asking for a one size fits all for every hospital, surely?

Dr SEIDEL - No, I am asking how do you respond to the need knowing there is a high occupancy rate, 114 per cent, in some locations and a much lower rate in other locations? How do you adapt to it?

Mr ROCKLIFF - I am advised through clinical services planning but are you talking more on a day-to-day, week-by-week circumstance?

Dr SEIDEL - You are giving annual averages here, so on the data you provided.

Mr ROCKLIFF - Right. Professor Lawler?

Prof LAWLER - Thank you. I would repeat the minister's response that part of the work that is being done through the clinical service planning is obtaining a solid and sound regional understanding of what the current demand is but more importantly what the project demand is. It is recognised that there will be ebb and flow in demand and that will be driven by a number of things. It will be driven by ongoing increases in the burden of chronic disease, the ageing of the population, demographic changes between regions and that will shift.

We will also have seasonal variations which will be reflected particularly in some of the communities on the east coast that do tend to wax during the warmer months and holiday period and wane. The other thing that will impact on annual occupancy will be the implementation of significant projects. The institution of ambulance secondary triage has significantly changed the number of patients who are requiring ambulances and also requiring transfer to local and larger emergency centres. That may well have an impact on occupancy as well.

The key is that all of these trends and changes have to be analysed in their context and they have to drive evidence-led and information-based clinical service planning. The outlying clinical servicing planning for each of the regions will not simply focus on the larger hospitals; it will focus on the needs of each region, which will go to community need, district hospital need and the secondary and tertiary facility need. Once that is developed, that will give us a very clear understanding, coupled with other elements of the Our Healthcare Future agenda, which includes Health Workforce 2040, which has a profession and specialty-based analysis of current head count versus national averages but will also look to some of the areas of particular pressure that will need to be worked upon. Those clinical service plans will then go to inform a statewide clinical service plan which will give us a solid and comprehensive system-wide understanding of what is needed.

Dr SEIDEL - Some hospitals aren't listed, for example, Dover, Franklin, Nubeena and Swansea. They are facilities that are operated by other providers. Do you have data on occupancy rates in those facilities?

Mr ROCKLIFF - I will take that on notice. I was going to update, Chair, if you don't mind. We have Swansea here. How about I go through 2019-20 and 2020-21, given that Swansea is not included in the submission?

CHAIR - Yes.

Mr ROCKLIFF - I will do 2019-20 as the first figure and the second figure will be 2020-21. New Norfolk District Hospital, 76 per cent occupancy, 84 per cent 2020-21; Midlands Multipurpose Centre, Oatlands, 52 per cent and 44 per cent; Beaconsfield, 80 per cent and 46 per cent; Campbell Town, 114 per cent as discussed and 75 per cent; Deloraine, 55 per cent and 56 per cent; Flinders Island, 29 per cent and 21 per cent; George Town, 56 per cent and 69 per cent; North East Hospital, Scottsdale, 40 per cent and 44 per cent; St Helens, 26 per cent and 30 per cent; St Marys, 35 per cent and 36 per cent; Health West, Queenstown, 37 per cent and 33 per cent; King Island, 27 per cent and 33 per cent; Smithton District Hospital, 56 per cent and 33 per cent; Huon Regional Care, 59 per cent and 15 per cent; Esperance at Dover, 44 per cent and 57 per cent; May Shaw Health Centre, Swansea, 67 per cent and 57 per cent; Toosey at Longford, 60 per cent and 70 per cent; and Tasman MPS, 100 per cent occupancy in 2019-20 and in 2020-21, 61 per cent.

Dr SEIDEL - And those facilities that contract out, do they also have access to the additional funding you provide for the safe staffing initiative? We heard earlier from a nurse in Swansea that there's no additional funding for them to employ additional staff, nursing staff in particular.

Mr ROCKLIFF - Thank you for the question. Professor Lawler?

Dr SEIDEL - Specifically for the contracted facilities. The reason I am asking, minister, is because during Budget Estimates you said that additional funding would also be available for the May Shaw centre at Swansea.

Mr ROCKLIFF - A particular safe staffing model, I am advised, is for district hospitals under the Tasmanian Health Service. The additional funding, I would have mentioned at Estimates, was to fund the additional continuing funding agreement.

Dr SEIDEL - And that's only for Swansea as the only contracted site or does it apply to Nubeena, Dover and Franklin as well? If not, why not?

Mr ROCKLIFF - Chair, if it's okay I might get Bruce Edwards, who I have introduced before, to come to the table.

Mr BRUCE EDWARDS NURSING DIRECTOR, PRIMARY AND COMMUNITY SERVICES (SOUTH), DEPARTMENT OF HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Mr EDWARDS - All of the contracted sites which Huon Regional Care manages for us, which is Dover, Franklin and the Tasman, currently are in negotiations in regard to their funding agreements. We are looking at what we consider to be safe staffing. That was one of the areas they raised with us, reflecting on what our current agreements provide to them. We are still waiting on some figures from Huon Regional Care. We presented that request to them about seven to eight weeks ago. Notification as at today was that they are still working on them.

Dr SEIDEL - Is that a viable occupancy rate for those sites, or KPI?

Mr EDWARDS - In Franklin, due to staffing issues - vacancies and concerns from local rural medical practitioners in July - we closed off the beds. That's why the occupancy for the 2020-21 year is down, I think 14 per cent. They were closed off till February and then there was a slow opening. Dover has three beds and mostly there are two beds occupied, sometimes three. Tasman is slightly different. It is a multi-purpose service so there's pooled funding from the Commonwealth and the state. The beds are considered to be flexible which means we can flex up and down depending on what the demand and needs are of the community in consultation with the community.

At the moment there are 18 residential aged care beds due to the occupancy being high, which I think was 100 per cent in 2019-20. They were using two beds, so with the flexible arrangement we negotiated that we would allocate four beds for the last 12 months. That's why occupancy overall has dropped, because of the increased allocation of the bed stock to sub-acute. It was based on increased demand and in discussions with the local rural medical practitioners.

Swansea has three beds. While the occupancies look low at times, on many occasions across these sites, and indeed probably in the north and north west, sometimes they are close to 100 per cent occupancy. Other times the demand drops. We are in negotiations at the moment. The additional funding through the election commitment will be included in that. May Shaw's issue was more about the increase in demand on emergency service. That is different to the other sites. It got an increase in demand through emergency care, after hours,

particularly during the summer months. While we review its whole funding and staffing, it could utilise that funding to try to increase staff while we finalise the funding agreement.

Dr SEIDEL - In your submission, when it comes to individual sites, you say that all sites are providing emergency services, so the double-tick in there. When you say 'emergency services', does it mean people actually show up, is it a triage service, or is there a difference between sites?

Prof. LAWLER - There is a service in our district hospitals that is able to provide an emergency response. The model will depend on the service in question. That may include the capacity to call in one of the general practitioners attached to the hospital and employed under the Rural Medical Practitioners Agreement to provide emergency-type care, depending on the nature of the facility. The arrangements that accrue to that visit will depend on whether the patient is admitted or discharged from that service.

Dr SEIDEL - So when it says on page 10, '24-hour emergency first response', is that the first response by a nurse, or when people walk in they can be looked after, or is it a call-out service?

Prof. LAWLER - I am not sure of the definitions of that datapoint. I wonder whether Bruce or Michelle -

Dr SEIDEL - Why I am asking is because it seems to be different in Swansea potentially to other locations. I am wondering why they all have the same tick, when it says, '24-hour emergency first response'.

CHAIR - You are asking does it mean the same thing?

Dr SEIDEL - Does it mean the same thing?

Ms MORGAN-WICKS - Each district hospital is of a different size with different FTE levels. It is a simplified table, to try to summarise emergency first response having that particular availability.

Dr SEIDEL - But is it a public document, it is on the website. So patients can show up after-hours to any of those sites and expect emergency services to be rendered to them?

Ms MORGAN-WICKS - Subject to advertised hours of care, and the staffing that is available on each of those sites.

Dr SEIDEL - A 24/7 emergency first response is what you have put in the table. Not subject to opening times - 24-hour emergency first response.

CHAIR - We are trying to clarify whether that is provided at the hospital, or whether that means calling an ambulance.

Dr SEIDEL - Well, it's related to hospitals. Table 1, district hospitals, clinical support services. I would imagine it's a hospital service at the hospital site.

Ms MORGAN-WICKS - For example, in the north-west, the emergency first response is 24/7, and the person is seen and triaged by a nurse. Bruce Edwards may be able to expand on the south, without going location by location. I don't know if that's the intention of the question.

Dr SEIDEL - No. The question is, for example, if patients present to the St Helens district hospital after hours, will they be seen by a nurse, and will they be assessed with regard to their needs and then treated accordingly? The same for Campbell Town, Beaconsfield, Smithton, King Island, New Norfolk - sorry, New Norfolk is inpatients only - the Midlands multipurpose centre, St Marys, Scottsdale, George Town.

Mr EDWARDS - Where there is a 24/7 emergency service at the hospital - which isn't in every hospital - a nurse is available to attend to patients who present, 24 hours a day.

Dr SEIDEL - But here it says it is every hospital - apart from New Norfolk where it says inpatients only. The contracted sites aren't listed so I'm not referring to them. Page 10, 24-hour emergency first response.

Mr ROCKLIFF - The Tasmania district hospitals report 2020, on page 15, details emergency care. People may present with emergency conditions at district hospitals, and some facilities will experience inpatient emergencies from time to time. District hospitals are equipped to undertake emergency services as described. Any TRDF as well.

In the Rural Medical Practitioners Agreement, a rural facility is labelled 1, 2 or 3 according to various criteria. The tier 1 facility is a rural inpatient facility that has contracted a general practitioner who is credentialled in emergency treatment, who continues to be contactable and able to attend the hospital within 15 minutes of being contacted.

A tier 2 facility is a rural inpatient facility that has contracted a general practitioner who has clinical privileges appropriate to the role and the facility, and who is continuously contactable and able to attend the hospital within 30 minutes of being contacted. However, the doctor may be unavailable by prior arrangement with the hospital for an aggregate period not exceeding two hours in any 24-hour period.

Tier 3 is a non-inpatient facility, but may have one or two observation beds, and has contracted a community general practitioner who is contactable during agreed hours, and who provides a continuously staffed telephone service when he or she is unavailable for any period exceeding two hours. The telephone service may include arrangements with other general practitioners, adjacent towns and/or statewide telephone triage services.

CHAIR - I am wondering whether inpatients is meant to apply to New Norfolk only?

Dr SEIDEL - You would expect if it is a hospital, someone has to be there. It is an inpatient emergency response. I think that is a given.

CHAIR - Yes, you can press the doorbell and someone would come. That is what that means.

Dr SEIDEL - It would be quite appalling if you had to call the ambulance if you were an inpatient to respond to emergency care. I don't think that is the intention of the table.

CHAIR - You might. I know we'd have a complication at the North West Private Hospital we'd call an ambulance when they needed to go to the regional, at times. I know it's spitting distance. That's what we did. I don't know if it still happens.

Dr SEIDEL - It is a simple question. Can patients present from the community to the hospitals listed here in order to receive emergency care 24/7?

Mr ROCKLIFF - I am advised that they can, Dr Seidel.

Dr SEIDEL - And they will receive emergency assessment and treatment if necessary?

Mr ROCKLIFF - We have an emergency response, but depending on the level of acuity and care that's required - Mr Lawler?

Prof LAWLER - Indeed, the answer is yes. It will be a process of assessment and triage by the nurse who is called to attend, who will be onsite. Then there will be a call to a specialist to attend, and the specialist will be most likely an RACGP or ACRRM. It won't be an emergency specialist. These are not classified as emergency departments, but they do provide an emergency or a medical response, if required.

CHAIR - Which would probably mean calling the ambulance, wouldn't it?

Prof LAWLER - The emergency response may be because someone is requiring immediate assessment and stabilisation, and on clinical assessment, that will be undertaken by the doctor who's called in for a tier 1 or tier 2 facility. That will result in treatment and discharge, or treatment and potentially admission into one of the inpatient beds within that facility under the bed cart of that treating doctor - or, if transferral or retrieval is required, then that may be an ambulance; it may be an activation of the Aero-Medical Retrieval Service, depending on the nature of the patient and the clinical assessment.

CHAIR - If a patient walked in and collapsed, you wouldn't wait for the doctor to arrive if they were 15 to 20 minutes away. You would call an ambulance, wouldn't you? That's what you'd expect your staff to do, wouldn't you?

Prof LAWLER - I would believe so. My understanding is that there would be emergency response policies within those facilities.

Ms LOVELL - Minister, looking at table 1 on page 10, under Pathology service, pharmacy service and medical imaging, they all have the double asterisk, and the footnote says -

> The level of these services available at the individual facilities varies, depending on factors such as the facility size, patient activity and available staff.

Can you give the committee more information about what the different level and range of services could be? What would be the basic level of service, and the most extensive level of service, for those three - pathology, pharmacy and medical imaging?

Mr ROCKLIFF - Yes, we can provide that, Ms Lovell. I will ask Angella Downie to assist us with that. I know pathology services have been a subject of this inquiry, in terms of King Island as well, where I understand pathology services are available one day a week at this time.

Ms ANGELLA DOWNIE, NURSING DIRECTOR, PRIMARY HEALTH NORTH-WEST, DEPARTMENT OF HEALTH, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

Ms DOWNIE - Was the question was around pathology for King Island specifically?

Mr ROCKLIFF - It was more around the asterisks, Ms Downie - the ticks around the pathology services available across the district hospitals. There is an asterisk -

Ms DOWNIE - Pathology, pharmacy and medical imaging all have the double asterisk footnote which says the level of service varies depending on factors such as facility size, patient activity and available staff. They are contracte services so in regard to pathology we have Sonic who are contracted from the north-west and depending on the level of need in the area, so the west coast has a five day a week service and an on-call. Smithton has a two day a week service and then there is transport - there are other requirements down there. Our staff can do that and transport the pathology through. On King Island, it is a day a week at the moment where they have a nurse who provides the pathology clinic. I think the need at the moment is being met, from what I understand in regard to the data that was presented the last time we looked at it. However, the contract is managed on the north-west base, on a north-west basis.

Ms LOVELL - In the instance a pathology, that could vary, a day a week would be the minimum at any of those facilities?

Ms DOWNIE - Yes, that is the minimum.

Ms LOVELL - And it could be up to five days a week, let us say?

Ms DOWNIE - No, not on King Island. It is contracted.

Ms LOVELL - No, across all of those.

Ms DOWNIE - Across all of them, yes.

Ms LOVELL - So, let us say, a day a week is the minimum level of service of any of those, up to five days a week. What about for pharmacy?

Ms DOWNIE - Pharmacy is provided by the North West Regional and we also have a primary health clinical pharmacy team that provide, in reach through videoconferencing, and support in that regard. They do not have a pharmacy on-site. We have our own imprest onsite.

Ms LOVELL - So, to clarify, minister, what I am after is not necessarily specifically for King Island, for example, or any particular hospital. But, if we say there is a varying level of service for pharmacy, what would be the minimum level of service available at any of those facilities and up to what would be the best level of service? I do not want to say best, but, I

guess, most extensive level of service. And again, the same for medical imaging, what would be the minimum level and what would be the most extensive level of service at any of those? Because they just have ticks. It is a bit hard to determine, one day a week is different to five days a week.

Mr ROCKLIFF - First, we can provide that clarity for you. Ms Downie might provide an example of pharmacy, or medical imaging potentially.

Ms DOWNIE - Medical imaging is another contracted service that we have visiting people come out to the district hospitals. Smithton, for example, is two days a week they visit down there. We also have two days a week down our west coast. On King Island, we have just installed or are about to install the new x-ray machine on King Island. We have installed new x-ray machines on the west coast and Smithton. The GPs in our rural medical contract arrangements are allowed to do limited scope. So, if we have someone attend our emergency response who requires limited scope, that is chest and limb, they can be attended by the GP on King Island. We also have a trained nurse who is able to provide limited scope radiology as well.

Ms LOVELL - Minister, if you are happy to take that on notice, I am happy to, for us to -

Mr ROCKLIFF - I am happy to take that on notice. I also refer again to the Tasmanian district hospitals report 2020, where it details services. On page 53 of that document, emergency response level, the 24-hour RN support, GP available in 30 minutes for inpatient, for example, including pharmacy, imprest pharmacy, local pharmacy during business hours, pathology, pathology service provider Monday to Friday and after hours as required.

CHAIR - On this minister, for example, on King Island, when there is only a two-days a week pathology for example.

Mr ROCKLIFF - One day a week.

CHAIR - One day a week, sorry. If an inpatient deteriorates and requires pathology, what is the process there to support that patient?

Mr ROCKLIFF - Wednesday and Friday clinics King Island, otherwise by courier. My understanding is though, that by two days, the latest information is that maybe one day pathology services is on the island, but that is correct.

CHAIR - What happens if the patient, who might be an inpatient who deteriorates? They might need follow-up bloods, or other pathology, or radiology, or pharmacy.

Prof LAWLER - The approach that we would take would be with any other district hospital in that a clinical assessment would be undertaken. If the services required, which would include definitive treatment, temporising treatment or investigations to guide treatment, cannot be provided on the island, then, there would be a discussion with the retrieval consultant through Ambulance Tasmania and also most likely, with the receiving consultant at the North West Regional Hospital. If there is a need to be taken to a larger facility of the receiving hospital, an appropriate clinical decision about location, treatment, disposition, will be made.

CHAIR - I am trying to establish what happens when the patient is not ill enough to be transferred but you do need some follow-up investigations. It is Saturday night - King Island and Flinders Island are particular examples here because there are not planes flying there, you cannot just put it on a plane. You can charter a plane but it is pretty expensive blood samples heading off. What's the process? Does the patient have to be transferred if they require further investigation? Do they have to be transferred at that time or is there another way of getting that test done and results assessed by a specialist or clinician elsewhere?

Prof. LAWLER - One of the challenges is if you want to test a patient's blood you have to either take the patient or the blood -

CHAIR - That's right, yes.

Prof. LAWLER - or take the test to where they are so there are point of care testing options that we do have but the reality comes down to if - so there can be an urgency to requiring a result which may or may not be related to the urgency or the criticality of the patient's status. If you need a test immediately that is going to guide the treatment in a significant way, then there is a likelihood that the patient is going to be sufficiently unstable that they will need to be transferred as well.

Obviously, that discussion and that decision will have to be made. I would say obviously, and as the minister has highlighted, in the district hospital report we do have a very clear delineation of what pathology, pharmacy and imaging services are at each tier 1, 2 and 3 facility which also goes to the level and nature of that emergency first response.

At King Island, as with any other remote facility, we would be taking a patient by patient decision on whether the patient is best served remaining there until a later time when a test can be done or whether they actually need to be either supported from afar or retrieved to a larger facility.

CHAIR - If we can move on to the body of evidence we have received, particularly in relation to the use of nurse practitioners. Many of our witnesses have expressed a desire to have more nurse practitioners in more areas of our rural health services. There is that aspect about expansion of nurse practitioners. What is the plan for that, if there is a plan? In what specialty and where?

I would like to go from there to look at nurse practitioners being able to work across their full scope but then also for people like pharmacists and paramedics and others, we will go down that path. I want to focus on that because it has been raised time and time again with this committee about the people out there whose skills aren't being fully utilised. So start with the nurse practitioners if you might, minister?

Mr ROCKLIFF - I will do that and recognise that this is a question that comes up quite regularly and I will access that information for you more specifically. We can talk about paramedic practitioners as well. Access to rural and remote communities, as I have highlighted, is an ongoing issue, Chair. They are not able to do general practice either in those challenges, workforce shortages and difficulty in recruiting and retaining health professionals across a range of disciplines, which is why we have the health recruitment task force well and truly underway.

While nurse practitioners, as you would appreciate, are not a substitute for a GP necessarily but they can increase access to health care for rural and remote communities. The Tasmanian Rural Generalist Pathway Coordination Unit is open to having a more multidisciplinary approach. There is a range of different nurse-led models of care that have been utilised in differing sized communities around the country. These include services in rural and remote areas, walk-in centres and urgent care centre models in larger centres and there is potential for Telehealth as I have discussed already today, including remote digital health monitoring services to augment these types of services.

There is currently no classification for a paramedic practitioner. Perhaps Joe can expand on this shortly.

There is avenue to further explore expanded roles for paramedics, however, within hospitals, rural remote communities, metropolitan areas and for specific roles such as vaccinators. Several other states have created community paramedic roles for paramedics to support primary health care needs in rural and remote areas.

It is broadly recognised that there are many qualified paramedics across Australia who do not work within ambulance services. Exploring roles for these health professionals across the health sector, particularly with nurse shortages, has the potential to provide what has been a very valuable skill set and increase the capacity for health services to meet community demand.

The expanded role of paramedics within the broader health sector is ideally undertaken by a professional lead such as a chief paramedic, as established in some other Australian and international jurisdictions. My understanding is that Victoria has a chief paramedic. This role aligns with the chief medical officer and chief nurse positions that look strategically at the evolution of roles and responsibilities for health care professionals across the health care sector.

On the subject of chief paramedic, we have chief psychiatrists as well, we are exploring what we need to do to support the role of a chief paramedic. There is some work to be done on that but we are open to the idea of creating the role of a chief paramedic to focus on clinical policies and areas.

CHAIR - Minister, while we are on the paramedics - we will come back to the nurse practitioners - I hear what you are saying about the chief paramedic being a position that could guide change beyond that. One of the key barriers, as I understand it, is some of our legislative provisions around the poisons act and things like that.

Do we have to wait for a chief paramedic position to be determined, decided, put in place, to address what we know are very real problems? Particularly in some of our regions in having available staff to provide the care as and when and where you need it. There are paramedics that could provide services to support general practice and support multi-purpose centres, and multi-disciplinary models of care.

What is your view about amending legislation to remove these barriers, not just to the paramedics but others?

Mr ROCKLIFF - I understand that the barriers to a paramedic practitioner is the Poisons Act.

CHAIR - And the Ambulance Act.

Mr ROCKLIFF - And the Ambulance Act. So that is an avenue. My view is, that we can look at a chief paramedic more in the near future. It is a good role because it is an independent role in terms of that independent view that has the authority to consider the service gaps that you allude to within ambulance, acute and community care and health services. In developing solutions to some of those challenges, I am very open to looking at a chief paramedic role sooner rather than later, notwithstanding legislation in the Ambulance Act and the Poisons Act is a barrier that needs to be undertaken.

CHAIR - Am I right, minister, in saying that you are not going to do anything about those known legislative barriers until you get a chief paramedic, and then let them look at it?

Mr ROCKLIFF - I will be seeking advice from the Health department, Ambulance Tasmania. Mr Acker might want to comment on this aspect as the best way forward. I am open to an expanded role for our paramedics to support care in our community.

Mr ACKER - Through you, minister, there is a lot of opportunity for paramedics to increase their scope of practice in Tasmania. We're all aware that paramedics only became regulated under AHPRA in 2018, so still a relatively new nationally regulated health profession. The acts and regulations have not been amended in many states and territories across Australia, like ours. That's because paramedics were primarily associated with the ambulance services.

In Tasmania since 2013 we've had extended-care paramedics. These are paramedics with advanced training. They can provide things like suturing, administration of antibiotics, tetanus shots, clearing catheters and those other important primary health initiatives. We have in the state 19 trained extended care paramedics, with six full-time equivalents. Right now, three in Hobart and three in Launceston.

Dr SEIDEL - They're working exclusively for Ambulance Tasmania though, aren't they?

Mr ACKER - Through you, minister, yes they are currently only working for Ambulance Tasmania, which is part of the restrictions of the act. We have just recently employed a senior pharmacist to help us look at the Poisons Act and regulations to understand opportunities to make amendments and to work with the PSB on opportunities to have not only ultimately prescribing rates by paramedics but dispensing abilities by paramedics. That's again, within Ambulance Tasmania.

Ambulance Tasmania is committed to advancing the scope of the practice of paramedics within the ambulance service. As a paramedic professional, I see incredible opportunities for the paramedic profession to play a major role in Tasmania outside of the ambulance service. As we've seen mostly in other countries, the UK for example, Australia is still evolving in terms of having paramedics work independently outside of state ambulance services.

CHAIR - Do you want to say anymore on paramedics?

Mr ROCKLIFF - Nurse practitioners as well?

CHAIR - I think Bastian might have had a question on paramedics.

Dr SEIDEL - I'm trying to nail you down, minister. Are you committed to create a chief paramedic officer role within the next, let's call it, three years of your Government, or are you just open to looking into it?

Mr ROCKLIFF - It's under active consideration and I'm waiting advice. Open to it and it's under active consideration, as I've said, and I'm waiting for advice from the department.

Dr SEIDEL - Are there any impediments, any barriers, that you've been advised on for the creation or that would be delaying the creation of the role of the chief paramedic officer?

Mr ROCKLIFF - I'm not into delays, I'm into action. So, when I'm advised that this is the good way forward, that's exactly what we will implement. Anything we can look at in other jurisdictions that is good policy, evidence-based, data driven, we will look at. Mr Webster might like to comment on this particular matter?

Mr WEBSTER - The context of this is a regulated health profession from 2018. We need to develop the profession of paramedicine and we need to take our time and not rush to answers as to things like paramedic practitioner as an answer to something which is an evolving profession. As Mr Acker said, we are looking at extended care paramedics, we are looking at the greater level of community paramedicine and issues like that that need to be worked through in some detail.

Secondly, amendments to the poison's legislation, putting on my hat of public health, we need to consider the broader implications of that, rather than an amendment that suits one part of the workforce that might have different consequences. We need to put all that together as a package. Regarding the role of chief paramedic, a lot of this doesn't rely on the role of chief paramedic. The role of chief paramedic is around clinical governance and the framework of clinical governance. That's an important step. All these other things have to happen as well. We aren't talking about something we can do in six months. We're talking about an evolving health profession. We need to make sure that we're getting the best evidence about how we evolve that profession.

Dr SEIDEL - That's why I specifically asked about the role of the chief paramedic officer, which would be independent of what the chief paramedic's actually doing with regards to the paramedic practitioner.

CHAIR - I understand though, through you, minister, that Ambulance Tas has a clinical governance framework. We were informed that at PAC. That's obviously a work that's been done and is in place, so we don't need that to happen before other matters are considered. Mr Webster was talking about the development of that.

Prof LAWLER - I think Dale's comment goes the intrinsic role, potentially, of the chief paramedic in clinical governance within Ambulance Tasmania, working with Ambulance Tasmania, but across the state - not that this would be responsible for a de novo development of a clinical governance framework, because as you say, there is one in place.

It is important to note that all of the other issues that are being discussed are not waiting for the chief paramedic officer to be developed. This is a role that could potentially add value

to discussions. Obviously we need to be clear around the interface, overlap and interactions between a chief paramedic officer and the Ambulance Tasmania structure itself.

I would like to acknowledge that Neil Kirby, who is a former chief executive of Ambulance Tasmania, has done some work in scoping out that role. As has been mentioned a few times, as a regulated profession under AHPRA, paramedicine is actually quite young. There is only one other jurisdiction I am aware of that has a named chief paramedic officer.

We have worked in discussions with that jurisdiction in understanding how that position adds value. There are opportunities to provide the same kind of chief clinical leadership in paramedicine to complement the leadership within Ambulance Tasmania, similar and parallel to chief medical officer, chief medicine provider, chief allied health adviser - those roles that provide key advice that is potentially independent of the service delivery arm, but works closely with the service delivery arm on opportunities to improve governance and to improve service delivery.

The role of the chief paramedic officer will obviously have a strong input to developing model of care, and strong input into the clinical policy and guidelines, but also recognising-

CHAIR - And looking at the full scope of practice.

Prof LAWLER - and working at the full scope of practice, in the same way we see the chief nurse and midwife contributing to discussions as nurse practitioners, and the chief allied health adviser contributing to discussions around extended-scope allied health professionals.

The role itself has some value. There is still a significant amount of work that needs to be done around scoping and clearly understanding it, but it is not something that is sitting there and holding back other work that are being done.

CHAIR - You mentioned about nurse practitioners.

Mr ROCKLIFF - I was going to highlight the Health Workforce 2040 strategy. As part of Our Healthcare Future, nursing and midwifery, page 26 talks around nurse practitioners. I am advised that the Office of the Chief Nurse and Midwife is establishing a statewide framework for nurse practitioners, creating a model of care that is ideally suited to the value of the nurse practitioner role. Rural or remote is a key context for this work and in fact, the work is being led by the Nurse Midwifery Leadership Group, which includes Ms Downie, who was at the table before.

CHAIR - Have you a particular number in mind of nurse practitioners who could be deployed around the state and particular areas? How many are you looking at and in what particular areas? That was the first question I asked.

Nurse practitioners operate within a scope of practice, and it is defined. I am interested in what areas you are looking at specifically, or what your leadership team is looking at.

Mr ROCKLIFF - Okay. I have some figures around nurse practitioners for you.

Ms MORGAN-WICKS - As part of Health Workforce 2040, which received funding in the last Budget, we are establishing those nurse practitioner candidate pathways. We are

completing the HR policy around that, and work now begins on the models of care and the creation of positions to support those models - and I regularly talk to the nurse practitioner in the emergency department at the Mersey community hospital, for example.

At the moment, we have nurse practitioners located around diabetes, burns, wound care, aged care, palliative care, ComRRS, oncology - but what the minister has mentioned is that have probably been putting them in as they have been developed, noting the Master's level study that is actually required to become a nurse practitioner, and that is noted in the health workforce strategies. With the number of positions that we get in any one year through interstate study - because it is not offered here in Tasmania - we really did need that framework, which was not just about a local hospital attracting a particular nurse practitioner role to it, so we can look in a more formalised and strategic sense as to where we should try to attract nurse practitioners to help in terms of the offered workload in those particular areas.

CHAIR - So if I am right, minister, and correctly hearing the secretary, this is being worked out now. You do not have targeted areas that are being scoped out. Is that right?

Ms MORGAN-WICKS - Through you, minister. I think we have close to 30 nurse practitioners already employed in the Tasmanian health service, and we have them in a variety of different roles.

What Health Workforce 2040 has done is said right, we have collected all the data and statistics in terms of our health workforce, and we are looking right across what we have today, what is actually required in 2040, and what the gap is, and how do we bridge that gap in terms of strategies. We have just received the funding in the last Budget under our health workforce strategy to pursue this work, so it is in early days of development.

We have nurse practitioners, but Health Workforce 2040 is about how do we formalise and be more strategic about where we are going to create positions and attract these highly qualified nursing practitioners.

Mr GAFFNEY - We heard recently from the AMA, saying that they had a shortage of 100 GPs, and with the age of our GPs, that's possibly not going to change quickly. We talked about other models from other countries. If you look at New Zealand, in 2017, 2018 and 2019 there was a 30 per cent increase in nurse practitioners; they've been fast-tracking 50 nurse practitioners a year now for the next so many years.

I understand the department is looking at where can we best fit the match, but in talking to the nurse practitioners that have approached us about letting them do their scope of work, the nurse practitioners are quite happy to find their own way forward, doing their own place, like Cygnet or whatever.

The fact that UTAS doesn't have a master's degree in nurse practitioners is a real concern, I think. I am not saying it is not going to get more attention, but I hope it gets done quickly, when it's a 2040 goal or aspiration and you have nurses out there who want to have that capacity - and there are eight acts here that have to be changed.

Some of those are minor ones, some of them are major ones. I hope it is not going to be a talkfest about where we will be by 2040, when we have 100 GP shortages, and there are models of care around in this state already that are showing huge advantages. We've been

having a presentation here this afternoon, and I visited one just a week or so ago about what they are doing, and if that group hadn't gone into that place, there would have been no or very little service in that area.

I am wondering if there is a way that yep, you can see this, let's get some training in place and make some advantage or some positives for those people.

Mr ROCKLIFF - We have made some inroads in terms of allied health and UTAS in recent times, Mike, which has been very positive, as I understand it. I take your points on board. I can assure you we are not going to be looking at 2040 and saying we will have that then. This is about scoping what we need now and into the future in terms of demand on services.

Ms MORGAN-WICKS - It's the difficult place around the funding of health care in Australia. In the THS, we cannot fill the gap of primary care service and provision. I am unable to confirm the number of general practitioners being quoted by the AMA, and otherwise accept it as given, but in relation to the number of general practitioners and the primary care support, we do our best in the middle - so between the primary care sector and between our aged care sector - to provide public health services that are at many times within reach into both the front end and aged care sector.

In terms of our nurse practitioner roles, we are looking at the application and use of nurse practitioners within the Tasmanian Health Service with the health services that we provide but noting that the Office of the Chief Nurse and Midwife is actually developing that framework. We work very closely with Primary Health Tasmania in relation to the types of skills, the practitioners, expansions in the scope of practice that we can help Primary Health Tasmania to support.

Mr GAFFNEY - How does that work with the different pieces of legislation that may need to be changed to allow the nurse practitioners to do that scope of work?

At the one time, you are doing a body of work here so do you say to the Justice department, Office of Parliamentary Counsel, 'Look, there is potential', or do we wait for this to get done and then say, 'Oh, by the way, now you've got to go and look at the acts that have to be changed to allow that to happen'. Do you see?

Ms MORGAN-WICKS - Yes. We don't wait for the Department of Justice. Acts or legislation that are administered by the Minister for Health or the Minister for Mental Health and Wellbeing fall within the purview of the Department of Health to suggest it usually and based also on public recommendations, feedback from our stakeholders such as the Australian Medical Association; the Australian Nursing & Midwifery Federation, the colleges. If they think that there's a particular scope of practice limitation that they would like to see addressed so that they can continue to run programs and courses for people to undertake.

Harking back to the example of the chief paramedic informing that advice in looking at the extension or the scope of practice issues, we would also look at the suite of legislative changes that would then need to be recommended. It's trying to do that in inclusive ways so that we can put up a package of advice to the minister so that the minister and Cabinet can consider it.

Mr GAFFNEY - I am pleased you have mentioned groups like the AMA, the Royal College and the ANMF. Is there the potential that one of those user groups may see it as a bit more territorial? Do they want nurse or paramedic practitioners to be able to do their full scope of work or is it going to impinge on their patch? We have some doctors who will say, 'We're overworked; we need as many as can', or do we have other groups representing a group of doctors who will say, 'Well, we don't really think that's a good idea', that sort of approach.

How do you, in your department, balance that up because for a while, with all due respect, the AMA was seen as 'the voice' for medical practice or health and it's not, it's the voice of doctors.

CHAIR - Some doctors.

Mr GAFFNEY - Yes. There are a lot of other groups out there that are representing different health groups.

Dr SEIDEL - I am listening, minister.

CHAIR - And the turf wars go on.

Mr ROCKLIFF - I appreciate what Mr Gaffney is saying. Incidentally, on page 14 of my submission from a primary health perspective, it goes into the increase per head of population of GPs over the course of the last six years so at least it's heading in the right direction in that sense.

CHAIR - Minister, did you say in the numbers?

Mr ROCKLIFF - It's heading in the right direction in terms of the numbers of GPs per head of population.

CHAIR - The number of GPs does not correlate with the hours worked by those GPs because the workforce is changing. It is much more feminised.

Mr ROCKLIFF - I understand that. Those figures are better and if they were reversed, I'm sure you would have pointed that out to me notwithstanding that it's an area of responsibility from the Australian Government which as a state government we are increasingly leaning into in terms of the needs for services, particularly in rural and regional parts of Tasmania.

I accept what Mr Gaffney has said. That's why the AMA's voice is important, individual GPs. I know a number of GPs who are not members of the AMA for various reasons but I still listen to them. When it comes to health recruitment and our Health Recruitment Taskforce, we don't just have the AMA around the table, we have the ANMF, the Health and Community Services Union and other key representatives of health workforce around Tasmania. We are listening to their areas of need, and together coming up with solutions on that issue of health recruitment and retention as well. You mentioned turf wars -

Mr GAFFNEY - It was Ruth who said turf wars.

CHAIR - Yes, I said that.

Mr ROCKLIFF - You might have replied turf wars. I understand it but we are not going to solve these challenges by listening just to one voice and not working together. This is what the Health Recruitment Taskforce is all about, and indeed the 2040 workforce plans for that as well.

Ms MORGAN-WICKS - We probably have some good examples during COVID-19 of where we have tried push scope of practice issues or traditional territorial views as to what should be done by a particular health practitioner. As a non-health practitioner, myself, I hold quite a pragmatic view in relation to our attempts to recruit and get staff in. For example, during COVID-19 for our testing clinics which started out with the Commonwealth suggestion that there should be a GP or a medical practitioner on site, we really pushed hard for nurse-led models. We have moved from what remains a nurse-led but replaced with assistants in nursing and are now introducing an HSO or a technician model under nurse-led, noting they are a valuable resource and that we need to use our nurses in other applications.

Similarly, in our vaccinations in pushing for the approval by the Director of Public Health for example, in expanding authorised immunisers so that we could for the first time in Tasmania's history, vaccinate over 400 000 people in Tasmania. We couldn't do this purely by a doctor-led or nurse-led model. So, from our perspective, we are very willing to consider all suggestions in relation to safe expansions of scope of practice. Whether or not I can position positions within the Tasmanian Health Service, according to the health services that we deliver, I will take the clinicians' and our administrators' advice in relation to that.

Mr GAFFNEY - Thank you.

Mr ROCKLIFF - We are expanding our pharmacists within the program as well in terms of flu vaccines to over 65 year olds.

Ms LOVELL - My question is related to what the secretary has talked about in the workforce and the role of the THS and understanding the delineation between the Commonwealth responsibility with primary care. For many of the people who we have been hearing from in these hearings, communities that don't have ready access to an acute or sub-acute facility; primary care is all they have.

We have had a number of examples and ideas put to us about the things that we've talked about, paramedic practitioners, pharmacists, scope of practice, nurse practitioners, multi-disciplinary teams that can work together to provide that level of care that is required or a more extensive level of care to those communities. Hearing what the secretary is saying about boundaries and limits in terms of positions for the THS and where those positions can be, what are those boundaries? As minister, are you open to trying to find opportunities for the state to play a role in supporting multi-disciplinary primary care teams in communities in conjunction and in partnership with the Commonwealth and private practice?

Mr ROCKLIFF - Firstly, yes. I guess some of the innovations in more recent times such as the Community Rapid Response Service (ComRRS) which we commenced in northern Tasmania, piloted in the north-west and the south. Now it has become established, working alongside community nursing as well. There is an example of nurses, GPs working together and supporting people who need a high level of acute care, but can be done in their own home.

Also, our emergency co-response team would be an example of that when it comes to mental health and police, paramedics and others working together to ensure that we can provide that care for people who are experiencing severe episodes of mental illness. Our expectation is that that will be up and running early next year, to alleviate pressure in our emergency departments. They are key examples around innovative models in addition to secondary triage which was established in February this year around -

Ms LOVELL - They are all examples, minister, of state departments working together, specifically looking at community-based primary care which is ordinarily a responsibility of the Commonwealth.

Mr ROCKLIFF - It is. That's why we are engaging with Primary Health Tasmania in terms of their care and ideas for care, which is Commonwealth supported as well.

CHAIR - How do we make sure the federal government stump up enough for their responsibility? This cost issue has gone on forever. Care that's provided in the public sector in our state hospitals is funded by the state and primary health care is funded by the Commonwealth.

Ms LOVELL - Yes, but what I want to hear specifically is what the state is willing to do? There is only so much we can do to get the Commonwealth to commit to funding where those gaps exist and are leaving communities with a dire lack of medical services and poorer health outcomes as a result of that. Where are you willing to step in and at what level are you willing to step in?

Mr ROCKLIFF - We are stepping in. Ouse would be an example of us continuing to step in. Our after-hours support initiative is a clear example as is the investment we are making into urgent care centres. With our investment in that after-hours support initiative we have received proposals from GPs, pharmacies to operate extended after-hours service for the local community. That is an example of us stepping in and providing that after-hours care service.

We're open to getting rid of some of those barriers that you talk about between Commonwealth and state, which has been a long-standing issue. The Australian Medical Association has been advocating for a single funded model which I have mentioned to them on a number of occasions when I have met with them, exploring what that looks like and how that might break down some of those barriers in the federal-state relationship.

Dr SEIDEL - Is that something that you would potentially support?

Mr ROCKLIFF - It is very challenging. As I recall, it was tried in 2007-08 by former prime minister Rudd who made some commitments in this particular area. At the time I thought that that was well intentioned and well-meaning. Of course the argy-bargy between the states and the federal government got in the way.

CHAIR - It became very complicated, minister, from my memory.

Mr ROCKLIFF - That's exactly right from my memory, and it was some time ago. The reason why I have engaged with the AMA on various matters, including discussion around the single-funder model is to try to extract from their point of view what it would look like and how it would work. I am still keen to find more information.

I would love for there to be a model where the argy-bargy between the states and the federal government wasn't there. It would make everyone's job a little easier. I'm happy to continue to engage in those sorts of discussions where possible.

I am advised that our rural medical services contracts for medical services cover at district hospitals engages GP services for the local communities as well. I have given some examples around Ouse, Bothwell and Tasman**.** There are other examples, I'm advised. We have 12 beds in the south that work with ComRRS hospital in the home.

Ms SEARLE - ComRRS being the GP in nursing service who are state and GP initiatives.

CHAIR - So the state fund's the nursing component of ComRRS, but the GPs are paid through MBS?

Mr ROCKLIFF - There's an example of it, Ms Lovell. Michelle, would you like to comment any further on that GP after-hours service?

Ms SEARLE - The purpose of the grant was to increase the after-hours primary care support to GPs. As part of that, we went out with two rounds. The first round we have targeted at GPs and at pharmacies. Those rounds have closed. Nine applicants were successful under the round. Six of those were received from pharmacies. We extended after-hours opening with six pharmacies. The remainder related to GP practices that were able to increase their after-hours support. The second round related to provision of primary care urgent services. In that round, we received six applications from GP services. We were able to approve all six of those applications.

CHAIR - Where are they from?

Mr ROCKLIFF - In round one, the successful applicants include Sorell Family Practice, Tasman Pharmacy, Deloraine and Westbury Medical Centre, Wilkinson's Pharmacy in Burnie, Ochre Health Medical Centre on King Island, Youngtown Pharmacy, Amcal Pharmacy Lindisfarne, North Hobart Pharmacy and Terry White Chemmart Health in Launceston.

The six successful applications under round two and one for the Hospital Avoidance Co-Investment Fund were the Sorell Family Practice, X-ray Newstead, Summerdale Medical Centre, Launceston Medical Centre, Your Doctor Hobart and the Pharmaceutical Society of Australia, which will use funding to incorporate an after-hours pharmacist by service into the existing GP assist structure.

Ms LOVELL - Not in rural communities or regional communities. There's Launceston, Youngtown, North Hobart, Lindisfarne, Sorell -

Mr ROCKLIFF - A very good initiative, nonetheless.

CHAIR - Is it likely to be expanded beyond the urban centres though?

Mr ROCKLIFF - We've had interest in round one and round two. It is open statewide, we're not just focusing on more urban areas. The initiative is open to all.

Ms LOVELL - Not to say it's not a good initiative but in terms of this committee and responding to the questions, it's probably not as helpful.

Mr ROCKLIFF - Perhaps there's discussion we need to have with people in rural and regional communities about why they wouldn't have submitted an application. What are the barriers to that? I think that would be a very good idea.

Ms LOVELL - One more question on the scope of practice issue that we've been talking about. One of the other groups that's presented to us in relation to this was the pharmacists. I understand we have a chief pharmacist already. What work has been done, or is that being considered to expand the pharmacist scope of practice and legislative change that might be required?

Mr ROCKLIFF - Before I throw to Mr Webster who's engaged with these matters in his public health responsibility, I will mention the NIP program and the expansion of scope in providing flu vaccines to people over the age of 65. This is a new initiative.

CHAIR - When did that start because that was an issue?

Mr ROCKLIFF - Very recently.

Mr WEBSTER - That will start in the 2022 flu season.

Mr ROCKLIFF - It was announced about a month or so ago.

CHAIR - The review of the scope? Where's that at?

Mr ROCKLIFF - We've committed to a review of the Tasmanian Pharmacists scope of practice. It would be to utilise specialised people within the department and will need input from key stakeholders, such as pharmacy and medical representative groups. Again, we need to conduct a high-quality, evidence-informed review.

The destructive effect of the pandemic means there remains many significant competing priorities to maintain public health and safety. Accordingly, the review is likely to be undertaken in the second half of 2022. It is a significant piece of work, and I want to ensure that it is appropriately informed and to the highest standard.

I have mentioned the influenza vaccine

CHAIR - When is it likely to be completed? That is the question.

Mr ROCKLIFF - The review is likely to be undertaken in the second half of 2022, and -

CHAIR - There is a quite a bit of criticism that it should be started earlier.

Mr ROCKLIFF - My understanding is it will be completed by 2023, I am advised.

Ms LOVELL - Early 2023, late 2023? Can you narrow it down to a quarter, even, of 2023? What is your advice?

Mr ROCKLIFF - Ms Lovell, that is my advice. As soon as practicable in 2023. I would like to say January, Ms Lovell, but if is February, you would all be into me about the minister promised this and didn't deliver and all those sorts of things, so I am going to be cautious about that - except to say that we want it to be informed, evidence-based, given it is a very important matter that can lead to better access to health services, and that is why we are doing it.

There are other competing interests, not only the pandemic, but add to that the significant health reform agenda and mental health reform agenda that Mr Webster is also leading at present. We are doing a lot and I look forward to informing the committee of the outcome of the review.

Ms LOVELL - It would be good if this review could inform some of those other reform agendas, perhaps.

Mr ROCKLIFF - Yes, I understand the question, thank you. Dale, do you have any further advice?

Mr WEBSTER - The chief pharmacist's role, in this context, isn't as described by the chief medical officer. The chief pharmacist is, in fact, a regulatory role, and it sits in Public Health services. There is an advisory role as well within the chief medical officer's branch, but the key here is that there is actually major reform underway within the pharmacy services branch, which is actually real-time pharmacy reporting and clearance, and this relates to how quickly we can actually give approval for high-level S8s through the process that is designed by the TGA.

We will actually have that in place by February or March next year, and you have already dealt with the legislative parts of that. Part of the delay in starting this piece of work is that it is actually a significant piece of work by the deputy chief pharmacist and a number of the pharmaceutical services branch. Staff are, off-line, achieving the real-time pharmaceutical projects, hence we have delayed this work, because we have seen that reform as more important and quite critical, given that it is tied to funding for community pharmacies and how they get money from the TGA through the Pharmaceutical Benefits Scheme.

Mr ROCKLIFF - I want to speak briefly about the work the Commonwealth is undertaking in primary health care, and point you to a report that was released for consultation last month - Australia's Primary Health Care 10 Year Plan 2022-2032, on future-focused healthcare, person-centred primary healthcare, integrated care locally delivered, supported by funding reform.

A Primary Healthcare 10-Year Implementation Oversight Group will advise on the design of key initiatives, monitor progress of implementation, guide evaluation, advise on adaptation of the plan and lead cultural change across the primary healthcare system. No doubt we will have input into that.

Ms LOVELL - One quick and very specific question that I hope you'll be able to answer with a specific answer. You mentioned Hospital in the Home. How close to patients it? Is there a limit to how far Hospital in the Home can extend from an acute facility? How close do patients need to be geographically, in terms of distance - is there a kilometre perimeter that you limit it to?

Mr ROCKLIFF - In the south we have I think 12 Hospital in the Home beds. The pilot is funded for 18, but we currently have 12 beds in southern Tasmania. In terms of proximity from the major hospital, Hospital in the Home is still considered an acute care setting - I stand to be corrected - and that acute care can be supported in the home rather than a hospital environment. Bruce, if you're able to give some information regarding Ms Lovell's question around proximity to the major centre, that would be helpful. Thank you.

Mr WEBSTER - Through the minister. In the south we have the 12 beds, and there is a geographical area, I suppose, but it will depend on the level of acuity and how many visits a day. So, generally it's within around 30 to 40 minutes of Hobart, from a travel time, but there are occasions when it will go further than that, because it's a model that's integrated with our community nursing. If the visit may only require one nursing visit with support from a nurse practitioner and the medical specialist at the Royal more remotely, then someone further than that 40 minutes will be provided with Hospital in the Home, with the community nursing providing the sort of face-to-face care.

Ms LOVELL - And that's only in the south at the moment, is that correct?

Mr ROCKLIFF - We have the mental health Hospital in the Home being expanded to the north-west, but in terms of our discussion, yes, in the south, I'm advised it is 12 beds in terms of funding. I mentioned 18 before, and I mentioned the 12 beds have been utilised, but it is funded for 12 beds. We're finalising the implementation and evaluation, because it is a pilot, and I'm expecting that is to be completed shortly.

CHAIR - What measure of success are you looking for there, minister? In your evaluation, what's the measure of success, as opposed to, this is not really working, we'll scrap this and look at something else?

Mr ROCKLIFF - My understanding is that Hospital in the Home, firstly, can take pressure off the hospital system, and secondly, I think there is evidence to support that people recover more quickly with Hospital in the Home.

Mr LAWLER - That's right. Through you minister, there is a reduction in the almost inevitable consequences of a prolonged hospital stay, such as air conditioning and the potential for nosocomial infection and other complications.

CHAIR - I'm just asking, what are you measuring? You can't measure an outcome if you don't know what you're measuring.

Mr ROCKLIFF - Uptake in support from health professionals, occupancy of beds -

CHAIR - But in terms of patient outcomes, what sort of outcomes are you looking for to measure success?

Mr ROCKLIFF - Professor Lawler mentioned one of those, in terms of patients -

CHAIR - Less deconditioning, yes.

Mr ROCKLIFF - Yes. Michelle, would you have more information on the criteria that Ms Forrest is seeking?

Ms MORGAN-WICKS - Through the minister, while Michelle is locating that information. In terms of the pilot, and in my conversations with the chief executive of Hospitals South on the use - and I've also met with the departmental head, Paul McIntyre - in relation to general medicine referrals to Hospital in the Home, actually training our clinicians to be comfortable in terms of the referral from a patient that they are able easily to access within a hospital environment, to actually referring patients comfortably into Hospital in the Home. Occupancy itself in a pilot program is one of our key indicators, whether we are able to fill the 12 beds, and certainly it has been a slower uptake that we have experienced in the southern trial. We have been working together in that education, training, comfort and support, to make those referrals through to a Hospital in the Home environment.

Mr ROCKLIFF - The criteria would be the readmission rate, as well.

CHAIR - That is what I am saying. That is what I am after.

Mr ROCKLIFF - Also, we are looking at expanding across the state, on the north and the north-west, as part of that $52 million commitment to do so in care in the community.

CHAIR - Minister, it is important to evaluate these things against performance measures that are meaningful, otherwise you keep spending money with things that might not be having the desired effect. I am not saying it does not. I am fairly sure it will have a good effect, but unless you have the data, it is a bit hard to be sure about that.

Mr ROCKLIFF - I agree with that. If I put my mental health hat on, and the HASI project that was undertaken in partnership with Colony 47, supporting people with mental illness, in accommodation provision. That was piloted, evaluated and it is now being implemented for a range of criteria that supported people with mental illness.

CHAIR - The reason I am asking some of this minister, is that a lot of these programs are put in as pilots, and they are evaluated, and some of them do not continue, some do. Many of the organisations we have talked to that provide services to the community, whether it be Dementia Australia, the Arthritis Foundation, basically have to reapply for their funding every three years, and that makes it difficult for them to focus on their core business.

When something is proven to work, let us say it is Hospital in the Home, for example, and you continue to fund it, why don't we use the same approach with some of these organisations that are supporting their communities with diabetes, dementia, with rheumatoid arthritis? If they have proven themselves, why do we keep asking them to spend a significant amount of time with very limited resources begging for money?

Mr ROCKLIFF - Point taken.

CHAIR - Okay, I will leave that with you to think about that. These are significant barriers for some of these small organisations. Do you any want to say anything else?

Prof LAWLER - Just some information about Hospital in the Home.

Ms MORGAN-WICKS - Noting that this still remains in draft, we are still formalising that through our evaluation and feedback process, we are looking at updating the current model of care for Hospital in the Home. Some of the suggested amendments include an increased scope and expansion of the geographical intake area for the south, providing alternative, or alternate clinic locations, and after-hours service. We are looking at the bed numbers and the utilisation, and whether that can be increased. We are looking at expanding to a seven-day model for admissions for the Hospital in the Home. My understanding is that the current pilot operated on a Monday to Friday, or five-day admission service.

We are looking at whether we can update and expand our referral pathways into Hospital in the Home. And I note, for example, the development of a flexible referral arrangement with general practitioners to refer in, and avoid an unnecessary emergency department presentation or inpatient admission. Do we have that direct referral from a GP direct into Hospital in the Home? That is the type of feedback that we are currently considering from stakeholders in relation to that service.

CHAIR - I will go to ambulance services, minister, if I may. We heard from some of our rural smallest services where they have a high reliance on volunteers, that because of the nature of the demand in other areas, volunteers are being taken from the community they are volunteering to, and then required to go to a neighbouring municipality. They did not agree to volunteer there because that is not their community as such. Not that they are overly complaining about this, but they are sitting in a lay-by area waiting because the ambulance service from that area has gone to somewhere else.

So, volunteers from the Huon are sitting at Kingston because the Kingston crews are over at New Norfolk, for example. I know we have talked about this at PAC but that's a different committee. I would like you to tell the committee more about how you determine what the service will look like where. From what we have heard, a lot of these ambulance volunteers are feeling disenfranchised by being required to fill all these gaps they feel should be covered by an increased number of paramedics, for example.

Mr ROCKLIFF - Sure, thank you for the question and I will throw to Mr Acker for some discussion operationally on the deployment models but more specifically in terms of volunteers. Recently, Mr Acker and I attended a celebration, an annual dinner for volunteer ambulance officer in Penguin surf club where we recognised five new life members. We launched the video which was a recruitment exercise which starred local volunteer ambulance officers as well to encourage people to consider volunteering for Ambulance Tasmania and being an ambulance officer.

I am we currently we have some 420 volunteer ambulance officers assisting Ambulance Tasmania. Recruitment is ongoing and we have commenced work with the Volunteer Ambulance Officer's Association on a memorandum of understanding to work together on an attraction, retention and also importantly training and support for volunteer ambulance officers as well. That is about a $50 000 commitment. I commend all volunteer ambulance officers.

CHAIR - Couldn't do it without them in our electorate, minister.

Mr ROCKLIFF - We couldn't, which is why they are highly valued and which is why it was uplifting meeting with many of them along with Mr Acker more recently. We will continue that engagement quite clearly. I might have mentioned before in other forums, an

example of what you speak of is King Island. I met a couple of volunteer ambulance officers on the island recently at the opening of the upgraded King Island District Hospital. Support is required for our volunteer ambulance officers, particularly in those smaller communities, because they may well be called out to a very serious episode, a crash or whatever it might be and quite likely know the person. This is an area that should, and will, and is requiring -

CHAIR - Which will lead me to the next area which is mental health.

Mr ROCKLIFF - increasing attention but in terms of deployment models, Mr Acker, can you inform the committee?

CHAIR - And how do you determine station size and that sort of thing?

Mr ACKER - I want to share the minister's respect for our volunteers. We couldn't do without them; they provide an invaluable service to our communities across the state. They also provide an opportunity to be fiscally responsible and financially responsible to the community. We have engaged ORH, which is called Organisational Research in Health, to do a five-year retrospective look at the calls that Ambulance Tasmania has responded to. That helps us identify the demand in each community. As communities have higher volumes of case load then we do know that it starts to significantly impact the volunteers' workloads. That's the stations that we identify for moving to career stations, as we recently have just done in New Norfolk. The New Norfolk station is now made a paramedic-only career station due to the high volume that we are seeing there.

The data that we are looking for in the next 10 years will also be informed by ORH looking at evidence through the ambulance response data and that will identify where we are moving to future career paramedic station and moving volunteers to other lower volume stations. We make this decision based on evidence.

Going back to the minister's question, and again through the minister, the deployment model that we do use is a demand deployment model to ensure that we are responding appropriately to high acuity patients. We would be wanting to have quick response times when patients are suffering severe medical and trauma emergencies and we move ambulances from low volume stations to higher volume areas where the next call is likely to be happening. As you suggest, Chair, that is impacting volunteers because they are moving from their communities to provide coverage. We monitor that and we are working closely with our volunteers to ensure we're meeting their expectations, as well as working every day to meet the performance of our system.

CHAIR - Minister, on the basis of the work that's been done, how many stations have been upgraded from a single-branch station to double-branch stations, and how many double-branch stations have gone to career stations in the last four or five years? I think Mr Acker said it was only five years that had been looked back at, so how many over that period have been upgraded?

Mr ROCKLIFF - Thank you, that is a good question. We might have to take that on notice unless Mr Acker can respond.

Mr ACKER - We should take that offline. I don't have the data top of mind for the last five years, but we can certainly provide that. We have been making changes currently with the

48 new paramedics and the new upgrades to Dodges Ferry and other places - Strahan, Ouse, New Norfolk, as I mentioned. We have made a number of changes from single branch to double branch over the last five years, but we can provide that.

CHAIR - Of the 48 new paramedics promised, how many have been employed, minister?

Mr ROCKLIFF - Since the commitment was made on the 1 May or this Budget?

Mr ACKER - We have 42 appointments, so 42 of those 48 paramedics are dedicated to stations, and we are recruiting six more. I understand just today that we've identified two paramedics for Campbell Town, and we have one spot in Strahan and I believe this is filled. There are probably three vacancies that we will be doing another recruitment very quickly to fill.

CHAIR - Is that above and beyond the 42?

Mr ROCKLIFF - The commitment is for 48.

Mr ACKER - Forty-eight positions. Forty-two are filled today, and six are being filled as we speak.

Mr ROCKLIFF - As part of that commitment, we are also doing a workforce scan for what we might need for future purposes.

CHAIR - What's your average age of an ambulance officer?

Mr ROCKLIFF - A qualified paramedic?

CHAIR - Yes.

Mr ROCKLIFF - I don't know.

CHAIR - As part of your workforce management.

Mr ROCKLIFF - Do you want us to inform you on that?

CHAIR - It's an important part of your workforce planning because, as you would know, the risk of trauma of being a frontline officer, as a paramedic, is a risk to mental health and wellbeing, and some ambulance officers may leave work earlier as a result of that injury.

How many paramedics have we lost from working for Ambulance Tasmania as a result of those sorts of psychological injuries?

Mr ROCKLIFF - We could provide that information, potentially. I just want to touch on the issue of wellbeing as well. You raised it first in the context of volunteer ambulance officers. My understanding is that our volunteer ambulance officers have access to the same mental health and wellbeing supports as our full-time paramedics, in terms of the health and wellbeing program for emergency service personnel through the Department of Police, Fire and Emergency Management.

More recently you might have noticed the workforce resilience scan undertaken by Ambulance Tasmania, which is very informative in how we support our workforce.

Perhaps Mr Acker might like to speak on that as well. This supports the cultural improvement and investment that we're very keen on, and I know Ms Morgan-Wicks and right across the Department of Health and Human Services we are all committed to supporting an improved culture - one of respect, and one of opportunities for growth and support as well.

I have a few figures on turnover, leading to your question. Ambulance Tasmania has advised the turnover rate for 2020-21 is 4.71 per cent, The Department of Health turnover in the same financial year is 9 per cent.

CHAIR - Maybe we need to be looking after the other health people better -

Mr ROCKLIFF - We need to support everyone, which is why we are having a lot of investment and support into culture within the workplace. It's been a stressful time, particularly in our area of representation.

CHAIR - I am interested in these figures, minister, because it seems that people in our community have trouble accessing psychological support for their own mental health issues, or their own trauma experience.

Our staff - Ambulance Tasmania staff or health staff - have trouble accessing that care too, because of the shortage of psychologists. Even getting in to see the GP can be really problematic for some.

I am interested in the distribution of this. Are we finding there are pockets where Ambulance Tasmania staff, paramedics, are leaving the organisation under a psychological injury? Are they getting the same level of care in all parts of the state, and the preventative care, to prevent them getting to that point where they feel the only option is to leave?

Mr ROCKLIFF - In that context, I will get Mr Acker to talk about the resilience scan that we released five or six weeks ago.

Also, the average age of a paramedic in 2019, was 39 years 6 months.

CHAIR - Pretty young.

Mr ROCKLIFF - Yes, true. I don't have the latest figure in terms of whether it is increasing or decreasing. A relatively young workforce.

CHAIR - We're not expecting a whole heap of those to retire any time soon.

Mr ROCKLIFF - No.

CHAIR - Retire because of their age, I mean. They might retire for other reasons.

Mr ROCKLIFF - Would you like to speak to the resilience scan and the work undertaken there?

Mr ACKER - Thank you, minister. I don't have the average age in front of me right now, but I suspect it is getting younger, because we are introducing a number of individuals that will bring university into our workforce, and in big numbers. The average age is actually going down.

We do have a number of mental health supports for our staff, as the minister mentioned. The main internal one is our peer support program which is available across the state. Staff who take advantage of our peer support speak very highly of the peer support group being provided. It is readily available everywhere in the state.

The other is the DBFM -

CHAIR - The volunteers can access that too.

Mr ACKER - Absolutely. Yes, all staff.

Speaking about the resilience scan, we engaged Frontline Mind to conduct a resilience scan, or a cultural scan of our staff. We know from the Damian Crump coronial, there's lot of issues identified with Ambulance Tasmania culture in the past. The scan did identify some challenges. My team and I have now been on the road over the last six weeks. We're just finishing 10 all-staff sessions, to speak about the findings from the resilience scan and identify action plans so we can improve the culture of Ambulance Tasmania.

The all-staff sessions have been very well attended by volunteers as well as paramedics, administrative staff and others. We're coming out in January with an action plan on how to improve the culture of Ambulance Tasmania.

CHAIR - Turning to the area of mental health and access to mental health services. You would be aware of the submissions. Your staff would have been aware of the submissions about the difficulty in accessing services, particularly in the North-West, but even broadly around the state; it's a challenge.

What specific actions are you taking, minister, to try and address this, because it is not going to go away? One would suggest more demand is going to occur as a result of the last couple of years everyone has lived through.

Mr ROCKLIFF - I can point to a number of areas that we have actioned, particularly when it comes to our investment in the Child and Adolescent Mental Health Services in the North-West, for example.

You might recall the Mental Health Council of Tasmania received some support to look at various areas of response across mental health as a result of the COVID-19 pandemic. They have completed nine or 10 reports. I launched the last one yesterday, at the Mental Health Council of Tasmania annual general meeting. That focused on the impacts on the community mental health work force.

The final series of the COVID-19 community sector impact reports will inform our planning response to the support of the mental health and wellbeing of Tasmanians, particularly in the community sector. That report demonstrates that the pandemic, as you alluded to

Ms Forrest, has exacerbated, many pre-existing challenges facing the community mental health work force in Tasmania. It's also clear, while the workforce has been impacted by the pandemic at a national, state and individual staff level, we can see a way forward in tangible opportunities to build a sustainable workforce and better equip them to support future events. Of course, we don't want any future events like we've been through; but there are a number of key priorities and immediate actions required from that report, including integrated workforce planning to support recruitment and retention; prevention and early intervention measures to address increased service demand; upskilling and diversifying the mental health work force; fostering and supporting the wellbeing of staff; equipping mental health services to respond to ongoing pandemic impacts; and data collection and monitoring to inform an effective response. We have a considerable investment in this area.

I mentioned the Child and Adolescent Mental Health Services review and our commitments to stage 1 and stage 2. We've already supported a statewide Clinical Director, Brett McDermott and his team. He is working hard to recruit people to support his team, statewide. One of the recommendations of the Child and Adolescent Mental Health Services review was to create a statewide service rather than a more regionalised service that wasn't anywhere near as integrated as it should have been. Professor McDermott's actioning that now.

CHAIR - Minister, how will young people on the north-west coast experience that?

Mr ROCKLIFF - A greater number of people on the ground as the result of recruitment will be supported through those actions, as difficult as it is to recruit to Mental Health Services. We are working very hard to do that; it's a national challenge if not global in many respects, particularly in light of the recent pandemic. There are the existing supports around Headspace and others; and we're discussing with the Commonwealth, extra supports in terms of the bilateral agreement that we're working on now. That will see co-investment to support mental health and wellbeing within our community. I have been speaking with minister David Coleman, on those aspects in more recent times.

Mr WEBSTER - The question of how does the young person experience that in the north-west? The first part of that is the broader policies - the child and wellbeing policy that the Premier's announced and particularly the greater psychosocial supports through schools and through the network of child and family centres.

The next step up is the sub-acute, which is the Head to Health model that the Commonwealth is producing for kids; it was previously called Headspace by the Commonwealth. We're making sure that that is in place and that was recently opened up in Devonport. The model there is about satellites around the area as well. Then, bringing in our programs which are at an acute level. Importantly, it is designed to deal with childhood trauma at the point of trauma so that it doesn't become an issue that creates long-term mental illness.

CHAIR - Intra-uterine as well?

Mr WEBSTER - That's right; the Perinatal and Infant Mental Health Service is part of the package that's been very strong in the south. We are extending that into the north and north west right now - that's happening this year.

There's a series of initiatives; but the really important thing is that it is integrated and as the minister described, the reforms bring in the Commonwealth reforms as well. For instance,

it's making sure that our integration hubs follow a similar model to the adult mental health centres that the Commonwealth are offering, so we have that range of services - the 'no wrong door' approach. If you're going to a community service, a state service or a Commonwealth service, you will get to the correct service that you need, as quickly as possible, rather than going through layers of bureaucracy and things like that. That's the major change. One of the early initiatives that the CAMHS reforms will deliver is the youth intervention program, followed very quickly by the out of home care program.

Mr ROCKLIFF - And more specific to the north-west - we have recruited additional staff to the community mental health services team, including the peer worker, carer peer worker, child and adolescent mental health services psychologist and a clinical nurse consultant, and GP liaison as well. Peer workforce is increasingly becoming more important as well in this space and indeed, the drug and alcohol space as well.

There's an investment of $1.9 million for a peer workforce coordinator; they will be based at the Mental Health Council of Tasmania to support implementation of the peer workforce strategy. We're investing $4.5 million to trial three Tasmanian Community Health and Wellbeing Networks in partnership with Health Consumers Tas. That commitment aims to empower communities to improve their health literacy and awareness and coordinate place-based preventative health initiatives, which may support wellbeing.

CHAIR - Minister, I know we're jumping around a bit but going to maternity services because this was done before the north-west maternity services review was released. We need to take a holistic approach to dealing with some of these matters, when you look at the impact of family violence on the intrapartum period. A trauma-informed approach needs to be taken to both mother and the baby around all of that.

Can you talk to us about what your plans are for maternity services? That will then lead into dental because that's linked as well. Everything's linked. Can we talk about maternity services, particularly the plan for the north-west? We've seen the review, understood your plan; but what's the timeline and schedule for that to deal with barriers or discrepancies in access?

Mr ROCKLIFF - Sure. The plan has been released, and that provides that continuum of care in the public service, right through from pre-birth, post-birth and throughout. Previously, it was fragmented, as you well appreciate, and we've had some discussion around that, Ms Forrest. The review, not unlike the CAMHS review, was very honest about the services and the like and how to improve the quality and safety and management when it comes to north-west maternity services. The contract with the north-west private service provider finishes in 2024. That gives us that timeframe to implement all the recommendations of the north-west maternity services review, which have commenced already, in terms of consultations with staff and other service providers. Professor Lawler, would you like to talk to that?

Prof LAWLER - Happy to, thank you. The process of moving towards developing the plan for implementing the recommendations of the review has already started, with the report being released on 8 October 2021 and the identification of key stakeholders, including the AMA who were obviously very vocal in calling for that review and they were briefed on 7 October.

Associate Professor Francine Douce, who has taken on executive leadership, has established a transition team and we are pleased to indicate that the project lead for that team is Adjunct Professor Debra Thoms who is a former Commonwealth chief nurse and midwife. We have also had recruitment to project support roles to commence in the next few weeks pending finalisation and intending to work to develop a transition plan prior to 30 June 2022.

As the minister has highlighted, 2024 being the end of the contract period will give us the time to work through many of the features of the recommendations, recognising that there are those two primary recommendations that are key, large pieces of work in terms of both the governance change to a single operator model and also the cultural work that needs to be undertaken. There is work being undertaken with connecting it to local clinical service planning and also the north west master plan which are key enablers of the delivery of an integrated service or an effective service.

The chief nurse and midwife and Professor Thoms spent time in early November, and last week, with Francine Douce attending the north west again on Wednesday and Thursday of this week, engaging with key local leaders such as the executive group nursing and nursing director, the chief executive of hospitals north and north west and midwives at North West Private and North West Regional and Mersey Community, with a plan for returning early December to meet with medical staff, clinical leaders and the EDMS who has recently returned from leave, with Professor Thoms being on site in the north west from 6 to 21 December to do some early intensive local stakeholder work and project development.

The priority discussions that are under way include the interim governance arrangements mechanisms that obviously align with the first recommendation, and also the cultural reform work to leverage work that is already in train if appropriate and will work with the nursing directors and the local leadership at the hospitals to give effect to that.

CHAIR - With regard to the scope of practice, is the overall intention to ensure that midwives can work across their full scope and across the whole region, including the Mersey, Burnie -

Prof LAWLER - As identified in the report, there were some fairly harrowing tales of the professional views of midwives employed across the region in terms of the structure and what it meant for their professional scope of practice and their professional satisfaction and the care that they felt they were able to provide.

My understanding is that the report, while it looks to the structure, the governance and the operation of the service between the two hospitals, looks at the delivery of maternity services across region and the intention is certainly that there would be the capacity to provide full scope of practice for midwives across the region, practising to their full scope.

CHAIR - Do you have a question, Mike?

Mr GAFFNEY - A different topic.

CHAIR - I want to touch on dental. Dental is covered and funded by the Commonwealth for public dental services, but dental health is integral to our physical and mental health and inclusion and wellbeing. With regard to lobbying the federal government to provide more support and funding, and ensuring that as many Tasmanians as possible can have access to

dental care, the co-payment is still potentially a barrier for some. Are you able to provide any information about barriers and your actions to address the barriers to access to dental care?

Mr ROCKLIFF - Yes, certainly. In the scenario, I agree with you with regard to oral health and the importance early intervention, and that would positively impact on the health for the rest of a person's life. I accept that and agree with that. We recognise that our waiting lists in this area need to be far less and, if my memory serves me correctly on the recent dashboard they had a marginal improvement, and that's starting. We've committed some $5 million to provide an additional 20 000 dental appointments statewide across emergency dental, general dental care and denture clinics. This funding will help mitigate the impacts on our oral health waiting lists as a result of the pandemic.

CHAIR - Is that to employ more dentists to achieve that and where will they be?

Mr WEBSTER - We're using the $5 million to voucher to private dentists to provide more right around the state in addition to activities to improve such as moving our denture process to a digital model which will increase our ability to deliver dentures more quickly and with less appointments. The $5 million is being spent in that way.

It doesn't increase the number of dentists within oral health but I'm very pleased that our most recent recruitment process has meant that we've been able to appoint nine new dental officers in the most recent recruitment which, at this point - and we touch wood - brings us up to 100 per cent occupied in our general officer role. It will have a massive impact in coming months on the dental waiting list. All of those things are promising, in addition to that.

CHAIR - Are they all around the state?

Mr WEBSTER - Again, all around the state, so as at the point of the recruitment, that fills up our dental officers across the state. We have a task in recruiting dental therapists and allied health professionals as well. We do have some vacancies in that area but we're working hard to fill those.

Mr ROCKLIFF - And a partnership with the Royal Flying Doctor Service of some $300 000 to support more services on the west coast, part of your electorate -

CHAIR - Smithton.

Mr ROCKLIFF - The west coast, the Huon Valley and central Tasmania as well.

Mr WEBSTER - We also have contracts in place with 10 dentists spread across rural and regional Tasmania, for emergency dental care for adults. That's in additional to what we've just spoken about.

Mr GAFFNEY - Two things have come to mind. One is that we've recognised in a piece of legislation about regional disadvantage, and that was the End of Life Choices Bill where there is a regional access standard. That's up to the department secretary to come up with that access standard and then publish that. My question is that because we recognise that our regional areas can be disadvantaged, is that something that may appear in other legislation down the track? Instead of having a piece of legislation that covers the state, it highlights the fact that we do believe that there could disadvantage. I'd be interested to see how that goes.

I'm not so fussed about the access standards now because they will be coming, I understand, but the other thing that was highlighted to us from a person who presented was access to services in regional areas is difficult when the transport is so poor and, he believed, the roads are so poor.

A recent example of the COVID-19 experience is that you've been taking the service out to the areas because of the desire to get people vaccinated in time, so the point of view that was put across was if there were services that wouldn't need to be full-time or even more than once a fortnight in regional/rural areas, isn't that a good way of operating, whether it was the dentist or whether it was any area that could be helped by using that as a model? Then that van or that place could go to that area for the week?

CHAIR - A bus full of allied health professionals.

Mr GAFFNEY - A single professional that could rotate around.

CHAIR - Not just a single one, get a few of them in the bus -

Mr GAFFNEY - I think to be serious about it you have to have a group of people who might be going, 'We can provide this service to this community for the next three days, and then we will go there.' You are rotating the service around, instead of expecting people from rural areas to travel to the major service centres.

Mr ROCKLIFF - Our vaccination program, as you mentioned, was a great insight in how to outreach and reach into communities, if I can use that terminology, and the RFDS partnership certainly was very successful in that sense again right around Tasmania. It will take a lot of learnings - Mr Webster might want to comment on this - around the vaccination program and I am sure that they could be applied around the state for other services potentially, and that would complement, if not support further, a range of specialists who do travel in regional areas at this current point in time.

Mr GAFFNEY - The 2040 plan might be looking at that, and the other question that I mentioned before about legislation that clearly identified disadvantage in regional Tasmania, whether that could be used in other pieces of legislation - health related - so that it is acknowledged up-front that services are not going to be supplied here and here and how do we deal with that from an act or legislative point of view.

Mr ROCKLIFF - To answer the question, Mr Gaffney, which is a good one, Ms Morgan-Wicks?

Ms MORGAN-WICKS - Through the minister - we already a range of outreach services and visiting clinics so we are happy to provide some further detail in relation to those but they also, I understand - I was just trying to find my list of them - I think it was in our district hospital report but I'm happy for the department to provide a list of existing visiting clinics and specialist services because it does vary from region to region.

CHAIR - Are you talking about an outreach list or not?

Ms MORGAN-WICKS - Inclusive.

CHAIR - Right.

Ms MORGAN-WICKS - But it would also be tied back to our clinical services planning which we are doing on that statewide basis to revisit exactly the service need. On regional disadvantage, that work is under way in terms of the VAD team who are working on that but I am happy to consider the work that is prepared there and whether that has application to other provision of health services and our policy and planning.

CHAIR - We are just over time, minister, but a couple of things I would like, if you could, provide to the committee later is the positions vacant at the moment across the health service, probably something you need to provide later in terms of the area, whether it is ambulance service or mental health or whatever, how many positions remain vacant or unfilled.

Mr ROCKLIFF - Focusing on rural, I know we provided a lot of information to Budget Estimates around the major centres more broadly.

CHAIR - Yes, I am talking about those services that are provided, like allied health in rural areas and positions like nursing positions or other positions in our district hospitals and we have talked about ambulance, I think they are mostly pretty much filled by the sound of that, but where there are vacancies in allied health and health professionals in the regions, I would just be interested to see what vacancies are out there.

Mr ROCKLIFF - We will absolutely do our best to provide information in the interests of -

CHAIR - I am not so worried about specialists in hospitals, I know they are a problem but they are relevant. We heard from the Arthritis Foundation that there is not a public rheumatologist north of Hobart and that's problematic.

Mr ROCKLIFF - Yes, we will do that.

CHAIR - All right. Thanks very much, minister. It has been a long session so thank you to your team and I don't think there is much we have got on notice for you.

Mr ROCKLIFF - I want to thank our team as well and those that contributed to the answers that were given and I appreciate their work at this present time, of course as they always do, given the many areas they are exercising us in terms of pandemic and other things so I very much appreciate that as well.

CHAIR - I do appreciate the workload of the department at the moment.

Mr ROCKLIFF - Yes, as do I, and I know that you do too, and this may be the last opportunity I sit face-to-face with Dr Seidel. I wish him all the very best and thank him for his contribution in this area. I listened to all the speeches following your speech the other night; they were very good and heart-warming. Thank you very much, Dr Seidel, for your contribution, particularly in this health space.

CHAIR - It made some of us cry.

Mr ROCKLIFF - I saw you tear up.

CHAIR - I did too.

Mr ROCKLIFF - Understandably. Thank you.

CHAIR - We will have a short break when you stop the broadcast.

THE WITNESSES WITHDREW

The Committee suspended from 3.41 p.m. to 3.48 p.m.

Ms ROBYN WALLACE, CLINICAL ASSOCIATE PROFESSOR, CALVARY HEALTH CARE TASMANIA WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Robyn. We appreciate you coming before the committee. You've probably been very disadvantaged with the number of cancellations and the impact on your business. We apologise for that, and thank you for being persistent with us.

This is a public hearing, it's being broadcast and all the information will be transcribed and form part of the public record and our report. Everything you say in front of the committee is covered by parliamentary privilege; that doesn't mean that extends beyond this room. If there's anything of a private or confidential nature you wish to discuss with the committee, you could make that request and the committee would consider it. Do you have any questions before we proceed?

Ms WALLACE - No, thank you.

CHAIR - I will ask you to introduce yourself and speak to your submission, which we thank you for.

Ms WALLACE - Thank you very much for having me and persisting with me as well. I will say straightaway that what we do for the health of rural general population, we do for the rural population for adults with intellectual disability. That is my main message. It is not the other way around what we do for people with intellectual disability, we do for the general population. We do for general population, I heard Ms Wicks talk about Outreach Services, we do for people with intellectual disability.

My statement is more about the problem and how we can potentially go about it. On one hand here, I have the Australian Commission on Safety and Quality in Health Care and on the other hand I have the NDIS Quality Standard indicators. There is a big distance between them and we need to bring them together, because we are going to involve health professionals and we are going to involve disability support people. There is a big grey area there.

I speak as a physician in internal medicine. I am in private practice at Calvary. I am in mainstream medicine, but within that I see adults with intellectual disability and people with mental illness from the physical health point of view. I have lived in Ulverstone for a couple of years, and had family and lived experienced with intellectual disability living in a rural area. I have lived in rural areas in Queensland for periods of time. I have spoken to colleagues in rural areas around Australia. I have read some of the terrific submissions to this committee, specially the consumers' group; and I have patients with intellectual disability from rural Tasmania. I teach and do research and study in intellectual disability.

Looking at the literature on people with intellectual disability living in rural areas, the main messages are they want to life in 'my chosen place'; because they are getting older, or they are adults, they do not want to have to move out of their own place, necessarily, if the services they want, the accommodation and the support is in the area they choose, which may be their rural area. This comes up as adults with intellectual disability age and leave their family home, perhaps into supported accommodation. And we have ageing groups, parents.

We have fewer group homes available in the rural area, and we have less choice for disability support options, and this comes up all the time. It is very relevant for health.

The families may not be IT-literate; there are problems with seeking disability options and working them out. The NDIS is much more complicated in an isolated area. There is less support and less access, and some do not know about the NDIS even now. There are issues in the rural areas, such as people with intellectual disability if they move out of their family home, they are more likely to live in aged care facilities. This is in the literature. I have not undertaken this study in Tasmania, but that comes up - younger people with intellectual disability living in aged care facilities.

We have carer burn out, loving parents; although there are a lot of positives about having family members with intellectual disability, there is a practical issue of being a carer all the time as well. It is tiring. Telehealth is less available as well, and the knowledge of the health system, that issue of health literacy, which is so important in the health commission standards. Partnering with consumers, involves health literacy which involves knowledge of health itself plus knowledge of the health system. Those two elements of health literacy which are difficult.

On top of that, or turning now to the health issues themselves among people with intellectual disability, there are high rates of medical problems. We know that. There are high rates of sensory impairment, so getting an eye check, does not have to be an ophthalmologist, but an optometrist, is more difficult in a rural area. Getting a hearing assessment - if you are living with a vision and hearing impairment and you are not able to express it, or is not detected, that is additional disability for you. The consumer report that was submitted here outlines the numbers, and, from the hearings, I imagine you know all about the lack of workforce in the health arena.

What I am suggesting is when, the minister's vision of health care in rural Tasmania comes up, when it is at the hospital area, at the district hospital area, when we go through the national clinical governance or the standards that have to be put up in that health arena, and that health setting - it involves consumers, managers, and clinicians. We also think well, what about consumers with intellectual disability? Consumers in that sense also means carers and the disability sector; the managers, the managers of the hospital, what does it mean for them in terms of the operational issues they have to instigate to make their hospital friendlier for people with intellectual disability?

Dr SEIDEL - Can I ask you a specific question? We talked about the smaller hospitals and their occupancy rate, do you believe or have you received information that it's because of standards issues? Standards aren't met. Occupancy rates are much lower than they could have been because, due to workforce or other issues, the standards as outlined by the commission can't be met?

Dr WALLACE - The standards are not met.

CHAIR - In any hospital?

Dr WALLACE - In any hospital in Tasmania. They're not specifically met for people with intellectual disability. There are no reasonable adjustments in place in clinical services for people with intellectual disability. The literature is there. We know about reasonable adjustments for palliative care, we know about reasonable adjustments for diabetes

management. People with intellectual disability, we know communication strategies. There is no centre or contact for people with intellectual disability in the clinical sense in any hospital in Tasmania.

Part of my submission that I gave to the Rural Health for Disability Services and the main health reviews is this need of this collaborative body to combine and bring these together. There's a lot of problem-solving to do to bring them together. For example, we've got the NDIS Code of Conduct; it's a beautiful code of conduct. Things they can and can't do. We've got standards of nursing staff, or allied health. Who does the showering? Who funds for the showering? Who gives the medications? There are models of care about that demarcation. They are out there. WA has a beautiful model. New South Wales has a model. It would need to be adapted for Tasmania but the models are there. Stuff is there.

There's not much new to do; it's bringing together known information and plans. They have to be duly checked for the standards in three levels; the consumers, the managers and clinicians. When you break it down like that, and you go through each of the eight standards, for example, from the health perspective, then it's manageable. It's not this great big amorphous thing, and how are we going to approach it? It's already there. We've just got to apply the known literature for people with intellectual disability and our known local situation in Tasmania. So, it's doable.

CHAIR - To follow on from Bastian's point, do you believe that it's doable for all of our mental regional hospitals as well as our major hospitals to meet the standard and still manage the needs of people with intellectual disability?

Dr WALLACE - We have to meet the standards and that's that.

CHAIR - But we don't meet them for intellectual disability?

Dr WALLACE - No, we don't but we can. We haven't put any effort in yet and we need to. So, for example, I would envisage that we'd have a centre at the Royal Launceston and the north-west coast as a point of contact. Perhaps this advisory body or someone would lead so that a mainstream clinician in all of those places would take the leadership of learning a bit more about the needs of people with intellectual disability, health and disability.

CHAIR - For example, if such a model is adopted, the person in Burnie would provide advice to Smithton Hospital, to Queenstown Hospital.

Dr WALLACE - Correct. Yes, that's right. At the moment I've got a patient in Smithton, they have a weekend down here for an annual visit. They make a nice visit of it but yes, they come down here for the weekend but that could be done at Burnie.

CHAIR - One could argue that for a person with an intellectual disability to be best served, they're best served closer to their family and supports in their local community.

Dr WALLACE - I think the dream is that every clinician, every manager, has a better view of people with intellectual disability and more competency. Over time, if there're models around, eventually it will pick up and be absorbed into the general clinical community. For example, I think how far people have come with indigenous health, how far they've come with non-English speaking people. At first it was a big ordeal, and how do we cope with it? Now

virtually every clinician in any situation across Tasmania would have a bit of a feel or know where to look for resources and it wouldn't be unusual

CHAIR - Why is it a problem with intellectually disabled individuals?

Dr WALLACE - I feel it's multi-factorial. There's an ethical thing where, incorrectly, this group's attributed low social worth. Knowledge and intelligence are regarded as very valuable assets. They are in a low socioeconomic status group; they occupy low socioeconomic status and that is associated with lowered health literacy. The disability supports which are meant to open up the world for people with intellectual disability and let them participate in the mainstream are not there when it comes to health. It's just not working.

I can work out a disability plan with a patient, what disability supports they need to access and participate in the health care. I can work that out. They go to the hospital and either the support worker is not allowed in or there's a fight between health and disability about who's going to fund it.

The COAG agreement between the state and national NDIS states that if a person needs disability support for their behaviour or their cognition, then it is funded by NDIS.

CHAIR - Is that with regards to the location?

Dr WALLACE - Yes, in regards to the location. I think in real life, there is room for some sort of sharing. That's another issue but it's a real practical issue of funding.

People with intellectual disability might be dropped at the door when it's recognised they're not well and dropped at the door of the ED or Smithton District Hospital or St Helens Community Centre and support workers aren't there and doctors aren't magic. With disabilities, we need to have a history, we need to examine the patient and the patients need help to participate in that normal health process. Our services need to be adjusted to make them friendlier; to have a place for the bed for the carer to sleep, to have meals there for them. That can be done everywhere.

In particular, at the moment there's no way of reaching the supports in the rural area very well, the same as there's no way to reach the clinicians. It's harder to reach them. I think the main hospitals are providing a source of expertise. It's the same thing you do for anyone else, except with these regional adjustments. It's not a brand-new topic, it's not as if intellectual disability is the illness. They could have heart, lung or rheumatology; it just makes the process of accessing health, understanding what the diagnosis is and carrying out the management is more difficult.

Most people with intellectual disability need disability support. This provides the standards, the rights and responsibilities of people with intellectual disability, including in heath. They provide governance and operational management for the service providers, they talk about the provision of supports, they talk about access and participation in health care but it doesn't happen. You've heard about the disparity of health outcomes for people living in rural areas; it's probably even worse for people with intellectual disability.

Dr SEIDEL - We don't have any outcome data, do we?

Dr WALLACE - We have some Tasmanian data on access to NDIS and services, which is lower.

Dr SEIDEL - In terms of health outcomes for people with intellectual disabilities?

Dr WALLACE - Not in Tasmania but in the written literature in New South Wales, Stuart Ward from UNE has outlined the increase compared to people in the city areas even lower health outcomes, rural compared to main cities.

Dr SEIDEL - Can you provide the inquiry with any specific information when it comes to know the difference people with intellectual disabilities have and therefore suffer more and potentially have worse health outcomes when they live, or choose to live, in a regional or rural area.

Dr WALLACE - As a population, people with intellectual disabilities, on average, have about six medical problems each. They can be people our age, or your age. Youngish people. That is a start. So, you have multiple medical problems. Already that is medical complication, but as a general physician, for example, we are used to people with multiple problems. That is what we do. They are harder to diagnose. There is a bit more complexity. You do need to history proxy and the supports they need are not there. That is the bottom line. The hospital system is not friendly. Parking is hard. The directions are hard.

Average life expectancy is 20 years younger. It is very similar to the indigenous population. The health profile, and morbidity and mortality. The rates of preventable adverse events in hospital are up to three to seven times higher than the general population. The rates of preventable deaths - 30 per cent. This is UK data. It is the same across the world.

Dr SEIDEL - So, is it fair enough to say that it is a huge need yet we fail them, because our hospitals do not even meet the standards to look after them?

Dr WALLACE - Correct, yes.

CHAIR - It is do with the intersectionality too. For an Aboriginal person with an intellectual disability living in rural Tasmania, your odds are not good for living a long life.

Dr WALLACE - That's right, and they probably won't. The data is there. There is very strong evidence that it is to the level of life expectancy. It is preventable. That's the thing. It is deemed preventable in the literature with analysis.

Dr SEIDEL - We talked about Aboriginal people and what effort we made to improve their outcomes. So, it is possible to do that.

Dr WALLACE - Yes.

Dr SEIDEL - So, why is it not happening for people who have intellectual disabilities. Is it: it doesn't really matter; do not want to talk about it; stigma or too hard; not on the priority list. Why is it?

Dr WALLACE - I think people get lost. I look at my relationship with colleagues at the Royal Hobart Hospital now. Most of my patients do not have private health insurance. I have

a clinic that is sponsored by Calvary which pays the admin costs. They come to me, but they might need tests at the Royal Hobart Hospital. Several years ago, when I started, I wouldn't not get responses. I would get shabby - even I knew that that is not the way you treat a condition outside of my speciality.

But I have persisted, and I am there as a back-up. I am there ready, willing and able, or someone else will be if it's not me. There is a source of expertise available and willing to help. I now get mostly magnificent support. Not always. It takes a lot of effort from these colleagues and the quality of care they provide is very good.

Inpatient care is still very concerning because there is no presence of expertise within the Royal Hobart Hospital. We really need a presence within the Royal. I am available for phone calls and all that but we need a mainstream clinician to take this on.

CHAIR - When you say mainstream clinician what speciality are we talking about?

Dr WALLACE - Any clinician can be a mainstream. When I say 'mainstream' I mean works in the public or the private hospital. I am not an intellectual disability specialist. I have developed a lot of skills in that area, but I am a general physician, internal medicine, and I work in mainstream. Within that, I have developed some expertise, and I have taken it on, learned it and blah, blah, blah.

We do not want a separate service for people with intellectual disability is a big message. We want mainstream with 'the reasonable adjustments' and working with the disability sector. Whatever good ideas for rural health, and the outreach and all that the minister comes up with - good. But let's make sure when there is a renal physician doing an outreach clinic in Smithton, and there is a person with intellectual disability renal problems, they know how to handle that.

CHAIR - It's like trauma-informed practice. Everyone should be aware of the impacts of trauma and we should have an intellectual disability informed practice.

Dr WALLACE - Correct, and as Dr Seidel was saying, in the profile of illnesses it's not unusual or rare. They might have unusual syndromes, but people die of constipation and urinary tract infections. They are not unusual problems.

Dr SEIDEL - Preventable.

Dr WALLACE - They're preventable and they take a bit of nuanced skill. It is hard to recognise but you just put on your cap and you are vigilant. In the perioperative situation, for example, it's acute kidney impairment and sepsis which are things that are problematic according to the literature.

CHAIR - Post-operatively?

Dr WALLACE - Yes. You take a proactive approach to look for those issues.

CHAIR - If you were the health minister, what would be the first two or three things you would do to bring these two things together?

Dr WALLACE - With me leading it, I'd set up an advisory clinical service in Tasmania, statewide. Its job would be to provide a clinical service for people with an intellectual disability and to provide a consultancy to colleagues who have patients with an intellectual disability. The advisory group would include the manager of the National Disability Insurance Agency here; Ms Porter from the commission would be invited; maybe someone from National Disability Services Tasmania; consumers; people with an intellectual disability; and we would problem-solve what do the clinicians need, how do we adapt all the different specialties, how do we adapt the operational aspects of the hospital and how do we work out the funding and the logistics of the demarcation of health and disability in the hospital ward. They are solvable problems.

Dr SEIDEL - May I ask you, then, you say, 'adapt' rather than 'implement'? Do you think there is room to adapt those standards? I am not saying we shouldn't adapt or just implement them. What do you think is realistic?

Dr WALLACE - People with an intellectual disability tell us as much as possible what there already is.

CHAIR - What you do for me, you do for any other person.

Dr WALLACE - Correct. Separate as little as possible. I think of 'adapting' with implementation as well, so we adapt to suit the population with an intellectual disability, the workers and families, and we implement them - the managers will help us implement them.

CHAIR - Is the question that we need to ask with the standards that have been set, that we do meet in hospitals for people without an intellectual disability, predominantly. There are times when things fall a bit short.

Dr WALLACE - Correct.

CHAIR - This is where the 'adaption' comment comes from. Everyone with an intellectual disability will present differently with different challenges. Obviously, they will have different physical ailments, maybe different mental health ailments.

If I hear what you are saying, Robyn, it's about adapting the standard to meet the need of the individual which is what you do anyway - we should with anyone. I turn up with my health problem and they have to adapt with my hearing loss, for example, if someone speaks on this side of me, I can't really hear them so you have to come around to the other side - that's adapting.

Dr WALLACE - Correct, so, person-centredness, perhaps.

CHAIR - Yes.

Dr WALLACE - How do you keep to the standards but adapt them to the individual person? People do that, but for people with an intellectual disability, fundamentally they need disability support to participate.

CHAIR - COVID-19 has created an overlay of problem here because there was a period - and it is still pretty strict in hospitals - where you can't have anyone else go in with a patient.

Dr WALLACE - But disability support workers are essential workers, this is an example so -

CHAIR - That's right but it hasn't always flowed through in practice.

Dr WALLACE - Exactly, because no-one knew the rules, but the rules were there, that support workers were allowed in. Parents might not have been -

CHAIR - Or a parent, not two.

Ms WALLACE - to visit, but support workers, essential workers were there. We had the same problem at Calvary until we sorted it out.

It means a fair bit of work to begin with, so it means every hospital policy, process, protocol and guideline has to be reviewed over time, or how do we modify this for the needs of people with intellectual disability? We have already done it for indigenous populations and non-English speaking people.

What are the modifications for people with intellectual disability? Calvary, for example, sends out all the policies for review to all the VMOs and they have been very receptive when I have been able to feedback and say, well look, for our patients with intellectual disability - there are not a lot but there are some - this is what I think, based on the literature, et cetera, needs to be done and they are very receptive and they will modify the policy.

CHAIR - When we are in our rural settings, this means that everyone who provides either a medical service through a GP, a pharmacist, allied health professional working in a community organisation or whatever, that is the hospital standard for the hospitals but what about the standards of care in our other health settings?

Ms WALLACE - Primary care is not covered, you are right, but say pharmacists - this is one area which does cover medication. There is one little snippet into medication and the pharmacists also have the home medication reviews. They are almost pretty good but should we say in the hospital or with the GPs in the rural area, can we just activate and make sure that there's a pharmacist looking at the medications, to remind the GP? Can we make sure we do that, about medication review and our own Disability Services Act, that we have a medication framework through DHHS for further advice for disciplinary support workers?

CHAIR - Do you think that then outside our major hospitals, things may be a little better or not?

Ms WALLACE - No. It's a struggle for everyone. It is surmountable to a large degree if not perfectly, I don't know, but there is a lot to be done to bring it up.

CHAIR - You said the first thing you would do as minister, you would establish an advisory clinical service. If implemented as you described, that would assist in our major hospitals and perhaps flow through to our smaller hospitals like Burnie, Mersey, Smithton, Queenstown and Dover, those sorts of places maybe, maybe not, what about the other rural health services? How would you address that?

Ms WALLACE - Do you mean GPs?

CHAIR - GPs and other providers of health care.

Ms WALLACE - The allied health community is already very advanced in their thinking of disability and that is in part because of their NDIS provider status or their training. With disability, they are not afraid of it, they are fantastic.

CHAIR - It is more when these people have to then engage with the acute health service that the problem emerges?

Ms WALLACE - They are more vulnerable. The health problem is more severe when it is at the hospital level and that has been my focus at that higher level.

GPs and specialists liaise all the time, we do. Most of my referrals are, for example, only for review. They might not have a specific acute medical problem and there are lots of things we find. With that service being available for the GPs there is a total diagnosis, assessment, management, and a plan that goes back to the GP.

Ms LOVELL - I imagine in some communities, particularly where you have a GP who has been there for quite a while and they have seen a patient with disability regularly, they would have an ongoing relationship and obviously have worked with that person for a long time. In your experience and what you hear in communities where they are relying on locums, for example, is that very difficult?

Ms WALLACE - It is a major obstacle and it is even the case in mainstream larger hospitals where you have got registrars or consultants and there is no continuity there.

Ms LOVELL - There is that turnover isn't there? Does that present a barrier for people living with disability to access primary care?

Ms WALLACE - It certainly does. It comes up time and time again, even in my small setting.

Ms LOVELL - That happens quite a bit in rural and remote areas.

Ms WALLACE - It does, it's a major barrier to improving things. There has to be in this advisory thing that I am talking about, some assessment and measurement of influence and is it working?

CHAIR - Impact.

Ms WALLACE - That's right, and clinical governance within it and so on.

CHAIR - This is meaningful performance measures.

Ms WALLACE - There is, and one way of measuring that would be, because at every level it is difficult. In morbidity and mortality meetings they might not be referred because the people will think 'oh, people with intellectual disability die.' So, they might not even sweep past the mortality meeting.

My view is that we do a proactive. We grab all the charts of people with intellectual disability and look at them with a framework of what we think should be the best standard, and work out - did it happen? What were the problems?

Ms LOVELL - I am surprised that that doesn't happen already, to be honest.

Dr SEIDEL - It doesn't. You mentioned Aboriginal health, the Closing the Gap report, we do this annually, but we don't do this for intellectual disability. Certainly not in rural areas. We don't even bother reporting on it.

CHAIR - That is why we bang on in this place about performance measures that are meaningful and actually measure the things that need to be measured. In terms of outcomes.

Ms WALLACE - Yes. I think adverse events is one big thing that is relatively easy to pick up and it is a good start and we'll know we will find stuff. I know we will.

CHAIR - Do you have anything else that you would like particularly like to tell us Robyn, that we haven't covered?

Ms WALLACE - Again, that main message is what we do for the health of rural general population, we do for rural adults with intellectual disability in terms of health. That is my message and I think it can be done.

CHAIR - Thank you, again, and we do apologies for our mucking around. One, was not our fault, it was the Government. The second one, was a person who escaped quarantine.

Dr SEIDEL - That is also the Government.

CHAIR - Thank you for your time.

THE WITNESS WITHDREW.

Ms KERRIE DUGGAN, NURSE PRACTITIONER/OWNER, AND **Ms HAZEL BUCHER**, NURSE PRACTITIONER (VIA WEBEX), CYGNET FAMILY PRACTICE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much both of you for attending. Welcome to the hearing of our Rural Health Inquiry. We thank you for your submission and being willing to appear before the committee.

This is a public hearing. All information provided is being transcribed and will appear on our public website. If there is anything of a confidential nature you wish to share with the committee, you can make that request and the committee would consider that, otherwise it is all public. Are you in Tasmania, Hazel? Yes? Everything you say is covered by parliamentary privilege, that may not extend beyond this hearing.

We will ask you to take the statutory declaration. Are there any questions before we start?

Ms BUCHER - No, thank you.

MS DUGGAN - No, thank you.

CHAIR - We invite you to introduce yourselves and make an opening statement. I know you've sent through some information for the hearing.

Ms DUGGAN - Okay. I've got an updated version of that one now.

CHAIR - Have you? Sure. Okay.

Ms DUGGAN - I'll leave the updated one.

CHAIR - Thank you.

Ms DUGGAN - Thank you for the opportunity to attend the meeting today. I've been a registered nurse for over 40 years, working in a wide variety of nursing specialities. I've got a post-graduate certificate in intensive care nursing, midwifery, general practice nursing. I hold a Bachelor of Education degree. I'm an authorised nurse immuniser and I've studied a Master of Nursing Science as a nurse practitioner. I'm saying that to show the study and the expertise that the nurse practitioner role brings to the health care setting.

I've been privileged to care for people when they are at their most vulnerable, and that is when they're sick or injured. I studied to become a nurse practitioner because 15 years ago I could see a gap in services, with people waiting to see a GP for a minor illness or minor injury and also for chronic disease management. I've co-owned a rural general practice in Cygnet for the last seven years - Cygnet Family Practice- and I've worked in rural general practice for the last 15 years.

I've also grown up in the Huon Valley on an orchard and I've got a wide experience of the needs of the rural community and access to health care, especially after hours. I believe that my education, experience and knowledge of general practice has enabled me to see a challenge, a lack of access for patients to health care, and if replicated and supported, turn it

into an exciting new model of care which is safe, efficient, loved by patients, cost-effective and can solve ramping and bed block. That is the model that I've implemented at Cygnet Family Practice, which is a holistic approach to healthcare.

It's happened out of necessity because up until probably last year, we've had a real challenge in getting GPs to come to Cygnet; some of the time I've been working as a nurse practitioner with a GP at the end of the phone. We now have five GPs with two more starting in the new year; but we know of practices where there's 14 GPs or 20 GPs and there's still challenges in getting access.

The model of general practice, I believe, needs changing. It's a business model and that's great because it needs to be a business, but it also needs to have an opportunity where people can get access on the day when they need it. If you have a urinary tract infection, you can't wait two to six weeks to see a doctor; and if you can't see a doctor then most people's default is to go to the emergency department. I'm suggesting that if we could support and replicate a model where you've got a nurse practitioner available - I see up to 28 patients a day, those 28 patients on one day multiplied by five, multiplied by every general practice, would certainly take a lot of people outside of the emergency room and have them treated in their own area where they prefer and also provide more continuity of care.

CHAIR - Did you want to add anything, Hazel?

Ms BUCHER - Thank you. Yes, I'm Hazel, different qualifications to Kerrie but a similar amount of time in the nursing workforce, so also a lot of experience. My speciality is aged care and mental health but I'm about to upskill into COVID-19 care.

My area of speciality where I saw the need was aged care. I'm currently working for an aged care organisation and working developing relationships in a share care model with a number of GPs across our nine sites in Tasmania, some of them quite rural, quite isolated. Again, it's an augmentation and enhancement of the health system nurse practitioner impact and provide more timely access to care for our patients in aged care.

Mr GAFFNEY - Hazel, you are a little bit hard to hear. You might need to come a bit closer to your microphone. You are just cutting in and out a little bit.

Ms BUCHER - Sorry, do you need me to repeat anything?

Mr GAFFNEY - No, we picked it up; but that's better.

Ms LOVELL - Kerrie, before we get started, I wanted to give you the opportunity to clarify what I think is a typo in your submission under workers' compensation.

Ms DUGGAN - There is. It should be 'work' not 'home'.

Ms LOVELL - Yes, so -

> If you injure yourself at home I can care for you fully. If you injure yourself at work I can't.

Ms DUGGAN - Yes. I am not authorised to fill out workers compensation paperwork. We currently have a submission into a committee there, to increase access for nurse practitioners to be able to complete the paper work.

Ms LOVELL - And that's legislated is it?

Ms DUGGAN - Legislated, yes.

Mr GAFFNEY - What's your likelihood of success with that, because it has been quite a while hasn't it?

Ms DUGGAN - I am not hopeful at all. The report from the chief nurse's office two weeks ago was they may approve nurse practitioners working in emergency departments to be authorised to complete workers comp forms but it is unlikely that nurse practitioners in primary health care will be authorised.

Ms LOVELL - And they have done that in Queensland?

Ms DUGGAN - It is authorised in Queensland.

Ms LOVELL - Any other states so far, or territories?

Ms DUGGAN - I believe South Australia.

CHAIR - Do you understand why they are making a distinction between emergency departments of our major hospitals and general practice?

Ms DUGGAN - No, I haven't been told what the difference is. In both places you are assessing someone who for example, we have areas where we have fruit pickers or cherry pickers come in and they might have cut their hand or something like that and they would present at general practice as well as ED. They are a similar type of patient that would present to both areas.

CHAIR - And they would be seen by a nurse practitioner in both locations?

Ms LOVELL - And you would be working under the same level of supervision in both facilities?

Ms DUGGAN - As a nurse practitioner, we don't need supervision as such. We have an area that we are qualified in, as does every health professional; if you are a podiatrist or a doctor or optometrist, you would know where your scope is and then if it is outside your scope as a professional, every professional makes that determination of where your scope finishes and where you need to refer on.

Ms LOVELL - That's what I meant so you would have access to the same level of -

Ms DUGGAN - Collaboration, yes.

Ms LOVELL - Yes, that's the word. Thank you.

CHAIR - To clarify, the scope of practice for a nurse practitioner in a GP practice for assessing a person who has come in with a cut hand as a result of a workplace injury, is the same scope of practice that would be for the nurse practitioner working in a DEM, that saw a patient with a cut hand as a result of a workplace injury?

Ms DUGGAN - Yes.

CHAIR - There's no difference in the scope?

Ms DUGGAN - No.

CHAIR - It's a bit hard to understand why the nurse practitioner in a general practice would be deemed to have a different scope than a nurse practitioner in a DEM.

Ms DUGGAN - I am not sure until we are officially notified of what the outcome is; and so, we would have to wait till we find out exactly what the outcome of the inquiry would be.

CHAIR - Sure. You understand that South Australia has moved in this way and what other jurisdiction?

Ms DUGGAN - Queensland.

CHAIR - They have enabled nurse practitioners within this scope of general practice and emergency medicine to do this?

Ms DUGGAN - Yes.

Ms BUCHER - If I can interrupt, I think that in Queensland and South Australia, their initiative, their point of starting was just ED and they are now looking to review that and have it expanded to GP nurse practitioners. In my specialty, as a nurse practitioner in mental health, I would like to be able to do that too. If I have a private practice and deem a patient is not safe and fit for work it would be handy for me too; it would be a different scope but again, based on my experience and my responsibility, my decision to take that responsibility on. As health professionals, we understand responsibility of workers compensation claims.

CHAIR - You are a nurse practitioner specialising in mental health; is that right?

Ms BUCHER - Aged care and mental health.

Ms LOVELL - Hazel, do you know, and you might not off the top of your head, when that change initially happened in South Australia to the NPs in emergency departments?

Ms BUCHER - I am not sure when they first started; I can get that information for you when they changed the legislation to allow ED nurse practitioners to be involved in workers compensation cases; but I'm pretty sure Queensland did both straight away and South Australia was a bit more cautious.

CHAIR - Before you move onto talking further on this presentation you provided, you said that the practice has been able to attract, I think you said, five new GPs and two more starting. How did you do that, because it seems to be a bit of a challenge?

Ms DUGGAN - It's been a huge challenge. Having GPs come to any rural area is difficult and I reviewed what Dr Lawler and Dr McArthur [? TBC] were talking about as well. We know that GPs are well-trained but they don't often choose to go to areas where they perceive that there's not support. In general practice, there can be long hours if you're working alone and some people are making the choice for lifestyle and family balance. It's been difficult. It's sort of happened gradually.

We had a GP move from the mainland -

CHAIR - To the area?

Me DUGGAN - Yes. They bought property and moved there and are raising their family there. They moved for lifestyle reasons. Then we had a GP registrar who came and stayed. Then we had another couple who have moved from Newcastle, a husband and wife who were friends of the first doctor so, that was a serendipity and nothing that could probably be replicated in attraction.

CHAIR - It's a bit of word of mouth, basically.

Ms DUGGAN - Yes, word of mouth and luck.

Ms BUCHER - Persistence.

CHAIR - Yes.

Ms DUGGAN - Cygnet is now a real growth area, and it's booming. People talk about it being like Margaret River was before that boomed. We are still not being inundated with doctors. I'd like to have another nurse practitioner join the practice because then I can keep the model going so we can have the access on the day, we can have medical, we can have nursing, we can have chronic disease management, the urgent care - everything; and most general practices don't have the access for the urgent care.

Most general practices, as a business, you're not going to leave a doctor's book open hoping that it will be filled. We know it will - but as a model, you want your books filled. It's easier to keep a day open with a nurse practitioner.

CHAIR - Does it enable you to provide some after-hours care as well?

Ms DUGGAN - No. At the moment, the GPs are choosing to work part-time to suit their lifestyle and their families, and so no-one in our team, even though we have, say, six health practitioners on our team, no-one has the extra availability to do more. We're doing COVID-19 vaccination clinics every second Saturday with a rotating roster, and getting extra casual nursing and admin to work with that and rotating our doctors through that.

Recently, an after-hours grant application came through and I thought, 'Great, I can do Thursday evenings now and some Saturdays', but the remuneration for the health professionals was at a Medicare rate. At a Medicare rate, I couldn't physically make it work with me, with what I get, to be doing that care.

CHAIR - When you say it was a grant?

Ms DUGGAN - It was an application for a supporter. I didn't even apply for it because I thought I can't make financially work.

Mr GAFFNEY - You have other allied health professionals working at your service as well; so, do the doctors feel supported in other ways?

Ms DUGGAN - We're looking to have a multi-discipline approach and we have a physiotherapist on site and a psychologist. That means we have more of a team where someone has, say, a musculoskeletal condition then the GP can refer to the physio and they don't have to travel and so forth. Trying to get access for locally.

CHAIR - We'll let you speak more to your presentation if you like. We sort of jumped in at you a bit.

Ms DUGGAN - For those who aren't nursing or medical here, I wanted to clarify one thing and it makes a big difference. Some people confuse practice nurse with nurse practitioner. A practice nurse is an enrolled or registered nurse working in general practice without further qualifications necessary. Some do but it's not needed.

A nurse practitioner is a registered nurse with five years' experience in their clinical specialty; expertise and authority to diagnose and treat people of all ages with a variety of acute or chronic health conditions. Nurse practitioners have completed additional university education at Masters level and provide patient care in an advanced and extended clinical role when compared to a registered nurse. They are the most senior and independent clinical nurses in our health care system. I think it's important to get that clarification.

CHAIR - Sure.

Ms DUGGAN - I will hand over to Hazel now. We are looking at a model change. We're looking at creating a paradigm shift to change in modelling. Hazel will talk to that idea.

Ms BUCHER - This, for me, is the key reason why it's difficult for nurse practitioners to get the recognition that we professionally could achieve. There's a key barrier. That's what Development in the Brain by Author and Hanson [TBC] say , and I don't know what page it's on but it's the third and fourth point down that -

> Even though randomised trials have found nurse practitioners just as medically effective as general practice doctors, we …

society -

> … only let doctors treat patients.

There's this caring as they name it. So, the logic, the rationale, all the evidence is there to say nurse practitioners are effective and great in teams and all that kind of stuff but we're still not getting much traction in Australia. I believe it's because this paradigm shift is needed.

The fourth point talks to leadership. The nurse practitioner development has got this far because of the support of previous governments. So, we need that little bit of support and investment from government because logic itself doesn't seem to be winning the argument.

I would be interested in your thoughts.

CHAIR - Even the numbers aren't speaking.

Ms BUCHER - No.

CHAIR - It's odd because the conservative government numbers usually do speak.

Ms BUCHER - We could be so effective in caring as in this model. You've already got nurses with experience in post-graduate training and then they put their hands up to commence a two-year education and mentoring versus the six years to become a doctor. There's opportunity there to help. Chronic disease is driving this change in the healthcare landscape. That's why GP practices are booked out for five to six weeks.

It's the same in aged care. I am really passionate about New Zealand where they've changed legislation. That's later in the presentation. They've changed legislation so that nurse practitioners in New Zealand can sign death certificates and cremation certificates and work completely independent as autonomous clinicians within healthcare teams. It's a big dream of mine to work under that model.

CHAIR - For a nurse practitioner who's been providing care to the patient in their home, not being able to sign a certificate of life extinct and having to wait for the doctor to come seems an extraordinary waste of resources.

Dr SEIDEL - The declaration of life extinct can be done by any healthcare practitioner.

CHAIR - Are you saying any healthcare practitioner can do that now?

Dr SEIDEL - Under delegation.

CHAIR - So, what do we need to change then that would enable that?

Ms BUCHER - There are two things. A life extinct form can only be signed by an RN when a doctor has delegated that they can. That's my understanding. In the [inaudible] I've worked with, I've authorised for RNs at the nursing homes to write the declaration forms. One of my dreams for nurse practitioners is that we can sign death certificates, and we can independently authorise an RN to sign the declaration of life extinct.

CHAIR - Sure, under delegation.

Ms BUCHER - From the RN, no. RNs can only sign a declaration of life extinct if authorised by a doctor. If the legislation changed and we were authorised to be able to sign death certificates, we couldn't delegate an RN to sign a declaration of life extinct as appropriate, or if it needs to go to the Coroner. That's a big dream and not for this table or this inquiry.

Ms DUGGAN - I might elaborate on the model of care that I can see is able to be reproduced in every general practice with support and funding.

While I've been waiting for GPs, I ran the practice with locum GPs coming in. That helped support the business until it grew but it also helped me have an innovative approach.

When people come into a usual general practice, they book to see a doctor as a new patient. That is their first visit. Usually, the file is empty, there is no record of any allergies, or of their medical history, their social history, their smoking; all that is empty. In our practice patients have that conversation with our registered nurses as the first visit. It's not just about filling in data, data is important, especially allergies and some other markers that we need, but it's also establishing rapport and building that relationship with the patient.

The more information we have in the file, the better healthcare we can do. I found that working in other practices, that people would have gaps in care. When someone goes to a doctor, they usually have an immediate need. In 15 minutes or half an hour, they come in with an urgent and important need. There is not time in our current system to go through the other things that are necessary to have a complete medical history in that appointment. While my health record has potential to be great, there are still a few gaps until that really takes off.

I have also introduced a new patient health check with me as a nurse practitioner. At the moment, Medicare gives a health assessment for somebody 75 years and over. In my opinion, that is too late for any preventative health care. We have health assessments funded by Medicare for Indigenous people, for people with disabilities, but there are people who are between 20 and 40 where lifestyle behaviour change can make a difference between developing a chronic disease or developing a cancer. That is a whole area that hasn't been well managed.

I see the ability by doing a health check. I do head to toe. I have found people who have had basal cell cancers on their hands when I have checked their blood pressure. I have found a melanoma on someone's back, I have found heart murmurs, simply because I have a system that works in teasing out all those things.

At the end of the consult, I identify that these issues need follow up with a GP, these issues need following up with me. We have reminders for any chronic disease management in place, reminders for their next health assessment. All that stuff is set up in the first couple of visits. My finding is that if it is not set up properly to begin with, it doesn't happen. It doesn't happen easily because we are focused on what you are seeing me for today.

CHAIR - If a patient comes in with say, an unmitigated headache or something, do you still see them first and go through all of that history? Or do they see the doctor to get some pain relief for their headache that has not been relieved by Panadol or whatever?

Ms DUGGAN - Are they are new patient?

CHAIR - Yes.

Ms DUGGAN - If a new patient came in and they were acutely unwell, if we could triage it, we would triage with the nurse and get some information. It's like when you present to emergency department, you get triaged by a nurse who takes the history, basic observations, makes an assessment of how urgent the care is. That would happen ideally, with one of our

registered nurses and then they would see the GP for an urgent situation. Then we would encourage them to come back and follow through to do our first visit new patient health check.

CHAIR - Which includes your social makers.

Ms DUGGAN - Yes.

CHAIR - Social determinants of health?

Ms DUGGAN - That would all be included. Base line observations, in different ages groups, then taking things like height is really important, for looking at risk with osteoporosis, osteopenia, those sorts of things. Doing all the base line things as a marker sets up the person's health for when people are looking back on how many centimetres have a patient lost in the last five years? Things like that.

Or we find gaps in care, like patients who come in with mental health issues. We often focus on their mental health but we don't do their blood pressure and we don't know that they are hypertensive. Having this system, sets you up for preventative healthcare and health screening and disease prevention and health promotion and then having the person go to the GP for any medical reasons and working out their whole care.

CHAIR - Obviously, that's a situation in your practice. Are you aware of other practices around the state that do a similar model?

Ms DUGGAN - I am not aware. I have been a nurse practitioner for 10 years now. I haven't got anyone following in my path as a nurse practitioner candidate. I know there was another nurse practitioner on the eastern shore in general practice, but I believe he has left that now.

Working in general practice as a nurse practitioner is extremely challenging because remuneration from the NBS - we would get paid less than a department of Health nurse practitioner, whatever level they are. They would probably be able to earn $20 000 to $30 000 more a year, so it is not really a career path.

CHAIR - You'd be asked why would you do it?

Ms DUGGAN - Yes. Why would they pay for a master's degree? Why would they do that? Most of the people who would do that anywhere are nurses who are living in the area, who are passionate about their community. They are going to stay there. They are going to keep working in that area, serving their family and community. They are the people who would do it, but it is not a clear pathway that is attractive at the moment.

CHAIR - What's the solution for that? Obviously, lobbying the Medicare Benefits Schedule, and the minister for health federally to address the investing challenges, which apply to GPs as well as to nurse practitioners, obviously. Is that the only answer, or are there other mechanisms?

Ms DUGGAN - I think needing to be creative. I do not know that MBS is going to be everything. I know we have federal government that looks after federal health and the state government that looks after state health. I think there needs to be a combination. What we can

do in general practice is keep people out of hospitals and emergency departments and decrease hospital admission days. The cost of providing funding or support for a nurse practitioner in general practice will be well and truly covered by people staying out of ED.

CHAIR - What I am hearing you say, Kerrie, is that you believe there is a place for the state Government to part fund a gap the cost of nurse practitioners and potentially GPs in some of these rural and regional areas where it is difficult to attract GPs and nurse practitioners.

Ms DUGGAN - Yes, and registered nurses. Looking at our budget, registered nurses get a work incentive payment. It's based on a complicated formula with how many full-time equivalent doctors you have, and how many regular patients and that sort of thing. But, it's not enough. Our bill to pay our registered nurses is over $100 000, and we get $40 000. Nurses do not generate income with the practice. They value-add, and that is great, but it is still a cost to running a general practice in a rural area where 80 per cent of your patients are bulk billed. It is difficult to attract people in a low socioeconomic area,

CHAIR - If state government invested in primary health by providing some funding for your nurse practitioner and your practice nurse as well, because that is an overhead of the practice, that has to be met from the costs of the patients walking through the door, effectively, because the MBS does not cover that cost to the practice, as such. It hardly covers the doctors' costs. What are we talking about here, and do you approach the state Government about that?

Ms DUGGAN - I think it is a no-brainer. There have been so many reports in the last 10 years about cost savings by supporting primary care better. There are lots of documents where we could find and how much it cost to keep a patient in hospital and how much it cost to not keep them in hospital. I suppose it is having the right time where the Government is listening to, seeing and doing something different.

CHAIR - Do you have one particular body of work regarding the cost-benefit analysis you could draw us to so we can say to the minister that this is just one of many, surely you can do the maths.

Ms DUGGAN - I do not have it in front of me, but I could take it on notice, and research, and get that information.

CHAIR - It would be helpful to have a body of evidence, if the committee was to make a recommendation around consideration of that.

Ms DUGGAN - Having some detail ready for them?

Mr GAFFNEY - How many patients did you have when you first started, and how many patients do you now have in your area?

Ms DUGGAN - We had a situation where I took over a practice when the GP left. We were left with 90 patients in 2014. We have over 1400 people who come to our practice as our regular patients, and that is based on a Medicare stat.

We have over 2500 people who come to our practice on our books. They come as far away as Dover, Judbury, Glen Huon, Middleton. So, it is not just Cygnet. It is quite a wide area. People come to our practice through word-of-mouth. People who like this style and their

friends have said this has not happened before. They have had a health-check with me and said that has not happened, and why doesn't it happen. I have explained that it is because not every practice has a nurse practitioner, or does not have this model working, as such.

Mr GAFFNEY - Both you and Hazel have extra qualifications, as you have to have. Do you think it is detrimental that we don't have those options here to have a UTAS course? Where did you guys do your extra study?

Ms DUGGAN - Hazel, do you want to start on that one?

Ms BUCHER - Thank you for that great question, I did my postgraduate certificates and diplomas at UTAS, but Kerrie and I both did our Masters at QUT. We got scholarships though the College of Nursing and went to Queensland University of Technology to do our Masters.

Most of the other newer nurse practitioners are at Flinders or the other major [inaudible]. It would be great to have. The role would be very visible if we had a course here. I know Dr Kathy Tori was brought over by the university to establishing a practitioner course, but we are just not getting the traction because the numbers are not there, because of the lack of visibility of the role. I think it needs a boost to start to be more visible and to demonstrate how effective the role can be.

I was thinking about what I said about the certificates, it is relevant to this standing inquiry, because if I could do those two formal [inaudible], I could care for patients independently in nursing homes as that's another area where GPs are struggling to meet demand. I would be quite comfortable doing that, because I have a lot of networks with the specialists, palliative care teams, and geriatricians and psychiatrists. I would relieve pressure from the hospitals in that space.

Mr GAFFNEY - Kerrie, talking to you before, you said that home visits are an advantage of having practitioners within an organisation because of what you are allowed to do. Doctors might not be able to do those home visits.

Ms DUGGAN - It is difficult. Doctors book up weeks ahead. To do a home visit, you are limited with time to leave the practice, go there and come back again. Often I would do a home visit and liaise with the GP. We would be share-caring like Hazel share-cares with people in nursing homes with the GP. So, we will often do a share-care. It is probably easier for me to get out of the practice than it is for the GP. Having said that, within our town boundary, if someone is palliative care or needs a home visit, we will make time for the GPs to do that.

Going forward, I have been liaising with Ali Spicer, a paramedic, and seeing a role for paramedic practitioners as being part of an urgent care response in general practice. I find that would really would value-add to our practice, because it would be easier for a paramedic practitioner to go to the home visits, the nurse practitioners would do the minor illness and injury, and chronic disease management, and GPs doing the medical, or the appointments that they do, and having sort of that all working together.

CHAIR - Currently there is a barrier for paramedic practitioners to undertake full scope of practice in the home, when they are not under the supervision of a medical practitioner. Is that right?

Ms DUGGAN - Yes

CHAIR - So, that would require a legislative change, as well as the opportunity?

Ms DUGGAN - That would. So, when they are employed by Ambulance Tasmania, once they leave that, they cannot practice anywhere else, they will have to re-skill or do another degree, and go into another are of health care.

Also, as a nurse practitioner, one of my roles is triage. Usually by 8.30 in the morning all the appointments are gone, even your book-on-the-day appointments have gone as well. So, if someone walks in and they have chest pain, or whatever, I have the flexibility to stop what I am doing and then to triage and do all that I can do to get that person ready for extra care. The GP can come in and do that part of it, and then they can go back to their patient, and keep going with their list and you have not got the GP patients being backed up for hours and hours while they stop and attend to emergencies. We are working in a team that way as well. This has increased access for our patients and, I think, it is a reproduceable model that could be done anywhere.

Hazel do you want to talk about your age care nurse practitioner model?

Ms BUCHER - I have alluded to that, yes. I have worked in couple of ways in an age care. I have worked with one GP across six nursing homes doing an 'inreach' model and that has been very effective. That was a shared-care model. Now, I am working for an organisation and struggling to find how that works. I work to my scope as a nurse practitioner for the organisation I work for, and do what changes I need to do for our residents, and then, sort of discuss that later with the GP who's generally external to the organisation. We have a couple of GPs in Hobart that just do nursing home visits. That's the preferred model because, as Kerrie was saying, general practice is so busy and it's hard to squeeze in a visit to a nursing home at the end of the day because they can't just pop in for five minutes - they have to be there for a couple of hours.

There's a number of ways I could see a number of models working in aged care; but my dream one is that I would be independent and be able to see patients on my own. Either way, the model, when I first became a nurse practitioner, was about expanding the reach of our medical colleagues because we're all busy and being able to do those things like write on medications charts. One of the nursing homes I work in, BESTmed, is the medication form and if you only have one or two GPs with a resident there, they're not familiar with that program, so I'm often writing up their medications for them, and working with them that way.

There's a number of ways that a nurse practitioner can support the care of a resident and do those timely interventions if someone's unwell, have those discussions with families - it's work that we could do. The organisation I work for has just invested in my role, which is the first one ever in all the years I've been a specialist in aged care. There's a couple on the mainland. Again, it’s not a visible role because it's just a commitment by an organisation; and it takes a pretty visionary one to do. I'm open to any questions.

Mr GAFFNEY - Kerrie, if you had two or three things to recommend for our report, what would be your priorities? What would you say this committee should recommend?

Ms DUGGAN -In my opinion, supporting the nurse practitioner and nursing role in general practice. In the Northern Territory, there's funding for support for implementing nurse practitioner roles. In New Zealand, they're now providing scholarships for 50 nurse practitioner positions for three years in a row and they're seeing the growth that way. It really needs some financial support and support for mentorship.

When I was studying, my mentors did not get any payment for their time, so that's all time that they gave up freely. In the model in Victoria now, they have supported the models but now they're changing the funding. I've got some information to leave with you; they're now doing funding to support mentorship and implementation of the role, rather than the actual role itself. New Zealand has a lot to offer and the Northern Territory and Victoria. If we can use what's happening in other places and replicate that, we don't need to reinvent the wheel. We've probably got the stats and data from those areas, that we can put together to give some statistics to say, this is where other people are now seeing the light and making a difference.

Mr DUIGAN - Without the MBS though, does it stack up, without being able to access that pool of money?

Ms DUGGAN - In the Northern Territory?

Mr DUIGAN - Yes, how does that work? How do you make a nurse practitioner pay her way or his way in that setting?

Ms DUGGAN - I think, maybe because of the remoteness in the Northern Territory there's probably other funding packages. I'm not sure of the detail there, Nick. I could have a look at how they're supplementing that, but they are offering roles. Like Hazel said, her organisation is now putting some private funding into the role because they can see the value of the role. With private funding, in my role I've had a philanthropic investor who's the other owner of the practice where I am and without that philanthropic investment, then this would have been a no-go because I couldn't make it work with Medicare; and being a low socioeconomic area, I couldn't make it work at all.

CHAIR - Which a lot of our regions are.

Mr DUIGAN - Yes. For this to take off, it needs that unpinning.

Mr GAFFNEY - Hazel, what would be one thing that you would want the report to include?

Ms BUCHER - Thank you, Mike. I think similarly, that it's down to the money; but those investment incentives for nurse practitioners to work within businesses to employ us. It is like with [inaudible] incentives. People can see that once the role is established and being effective, it will just start growing its own and then I think we will see change will happen everywhere. We are just not getting up into that change momentum space. I think incentive payments and GPs and [inaudible] in GP areas like that for nurse practitioners [inaudible].

Mr GAFFNEY - I am not sure if both of you heard the conversation, but when the minister was here, there were quite a few questions asked of the minister and the department about the roles of nurse practitioners, and paramedics and pharmacists as well. They did put

forward some direction of what there were trying to do and how they felt, I think that was fair to say. It would be well worth getting a copy or listening to Hansard -

CHAIR - The *Hansard* will be up in a week or so.

Mr GAFFNEY - The *Hansard* will be up in a week or so, to get that and read over it because there were some suggested ways forward that they were looking at that you may be able to link into.

Ms DUGGAN - Yes, that sound great.

CHAIR - I did notice in New Zealand, the law changes resulted in 30 per cent increase in 2017-18-19. Impressive result with that support from that New Zealand government.

Ms DUGGAN - Yes. I have a little handout here to leave you and that was the frequently asked Questions and Answers with the 2018 legislative changes. It's got the amended acts - there was the Holidays Act, Burial and Cremation Act. A lot of the time it wasn't like an onerous legal change. It was like changing 'medical practitioner' to 'health practitioner'. I will leave that in here as well. It made a difference because it took away some of the barriers for access for patients to receive care.

CHAIR - I know New Zealand is a different country, but sometimes we don't treat them as such. Do they regulate the health practitioners under AHPRA or do they have their own regulatory system?

Ms DUGGAN - I believe AHPRA is an Australian regulatory system. Would that be right Hazel, Bastian? Yes, Australian. The nurse practitioner title is protected under New Zealand and Australian law. If you work in New Zealand as a nurse practitioner, it is the same standard as here.

CHAIR - Where does, if any, the biggest resistance come from to accepting of nurse practitioners? Apart from the lack of awareness of the role. Where is the resistance that may come, and how would we deal with that?

Ms DUGGAN - The resistance will come from different medical practitioners, because I don't think they understand the role. I found whenever I've worked with a general practitioner they understand what the role is and they understand the knowledge and skills and the collaboration required. Doctors that haven't worked with a nurse practitioner, often don't really understand the detail of the role and so they are often very cautious about safety aspects and so forth. It is important to give information to those GPs. I have been looking to meet with AMA, RACGP and I have done that previously just to ask, 'have you got questions?' Can we help you?'.

CHAIR - And the rural doctors might be good.

Ms DUGGAN - Yes. Even with one of our senior GPs, Maureen Ryan, to go along as a team and say this is what we do. That is where the opposition comes from, and that is where the opposition's coming from with the workers comp committee as well. We have groups there that are cautious about any change.

Ms BUCHER - Can I add a tiny bit to that. I agree, and I think the resistance is that we didn't learn our skills the way our medical colleagues did. They don't trust the way a nurse learns if you like, that we don't have that really intense university training.

As nurses, we learn the same stuff at a totally different level, I understand that, and a totally different arm of health care. But, over the years we gather and absorb and learn so much and that's what hard to quantify - as a nurse practitioner how we can be as effective in that space as medical practitioners have the six-year solid scientific learning. We just learn it differently and it is hard to quantify that.

I think there is a misunderstanding or dismissal of our way of nursing or manner of learning, if you like, despite the [inaudible] and rigorous training and management and regulation by AHPRA, and the evidence that says we are as safe and as effective in our spheres of specialty.

Mr GAFFNEY - With workers compensation, groups have been asked if they had any objections or had any comments to provide information to whoever looked at that. Are you aware of any groups that provided information and if I was to suggest a couple, could you say yes or no?

Ms DUGGAN - Yes.

Mr GAFFNEY - The AMA?

Ms DUGGAN - Yes.

Mr GAFFNEY - RACGP?

Ms DUGGAN - Yes.

Mr GAFFNEY - Any other group? ANMF.

Ms DUGGAN - I am not aware of the others -

Ms BUCHER - Yes, the ANMF definitely.

Mr GAFFNEY - Okay.

Ms DUGGAN - I believe that would be the barriers that would stop changes.

Mr GAFFNEY - Okay. Thank you.

CHAIR -. We are out of time. Is there anything you particularly wanted to say, Kerrie, before you finish up that you haven't mentioned?

Ms DUGGAN - I will table this one. This is from the Northern Territory and this was the letter sent to students who were studying their Masters and Alex Spicer will elaborate when she speaks as well. I thought I would include that because that's one state that is going ahead. Victoria is leading the way and it is because it has the financial and the political support going

forward and they have had drivers that support the role. In other states, there haven't been those drivers politically.

CHAIR - If you want to leave those with us, that would be great.

Ms DUGGAN - Thanks so much for your time.

CHAIR - Thanks very much. You can stop the broadcast.

THE WITNESSES WITHDREW.