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To: Rosalie Woodruff; transferofcare
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Subject: Submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping)
Date: Saturday, 27 January 2024 8:00:07 PM

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I would like to thank the Select Committee for the opportunity to make this late submission to the inquiry.

I have noted that one submission highlights a lack of 24/7 radiology and pathology at the LGH. By making this submission I hope to provide some context to how Medical Imaging (radiology) services are delivered at the LGH and specifically address the claim that the LGH lacks 24/7 radiology services

Background: from early 2003 to September 2021, 18 years in total, I was the Chief Radiographer and Operations Manager (Head of Department) for the Department of Medical Imaging (Radiology) at the LGH. I, therefore, have intimate knowledge of how this service is delivered and how it has changed over many years including the activity for all modalities. I am well placed to discuss activity growth over time, both within hours and after hours (on call), how this impacted and how radiology responds to ED and other hospital requests for imaging.

What does the Department of Medical Imaging (DMI) do?

The DMI is a complex service that deliveries medical imaging across a range of modalities for imaging. This covers traditional x-ray service, mobile x-ray for ICU and wards, fluoroscopy, mobile image intensifier (II) in operating theatres, CT Scan, MRI, Ultrasound, Angiography and associated interventional procedures and Angiography for coronary angio/interventions. Professional staffing (radiographers and sonographers) FTE to cover all these modalities as of September 2021 was approximately 25 FTE. Qualified staff are not trained in, or experienced in, all modalities. Ultrasound, for example, requires training and post graduate qualifications/ accreditation while specialised modalities such as CT, MRI and Angiography require post graduate training but not necessarily specific qualification. It is not as simple as thinking that any radiographer can do everything.

Across all modalities the typical hours of operation are weekdays 0800 to 1700 except for x-ray, including mobile x-ray and operating theatre II, which is provided via a 7 day a week shift roster from 0700 to 0100. Outside these hours, all modalities are covered by an on-call service 24/7 except ultrasound and MRI which have some overnight limitations due to staffing constraints. X-ray, CT Scan and Coronary Angiography are supported 24/7 with no limitations. It is worth noting that to deliver these on-call services the department maintains 5 separate on-call rosters outside the shift roster for x-ray. With a professional staffing FTE of only 25 covering 5 on-call rosters and a shift roster this means that staff in

the speciality areas are required to have an on-call rota that can be very arduous.

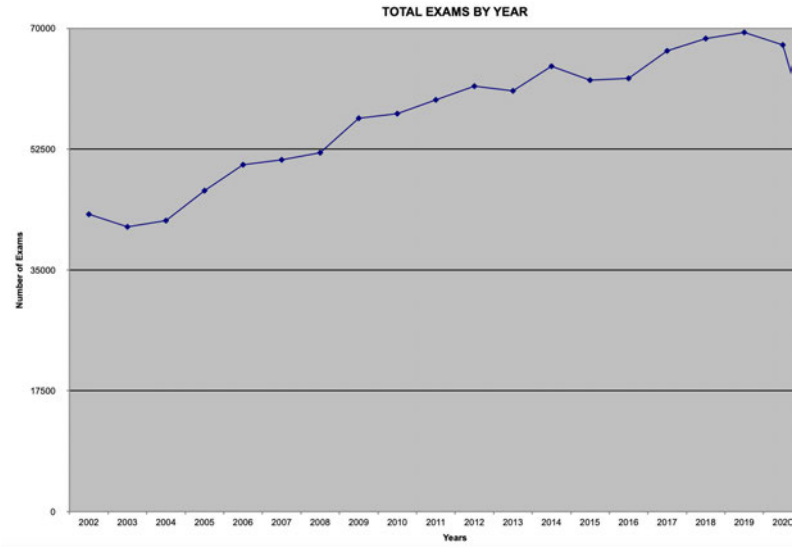
In effect, the most heavily used on call service (CT Scan) is on site throughout the evening and night due to the number of scans performed on-call. There is little delay between time of request for scan and the scan being performed. Typically on-call staff are on-site within 20 minutes of being called. The scans are read remotely with a turnaround time of about a hour for the report.

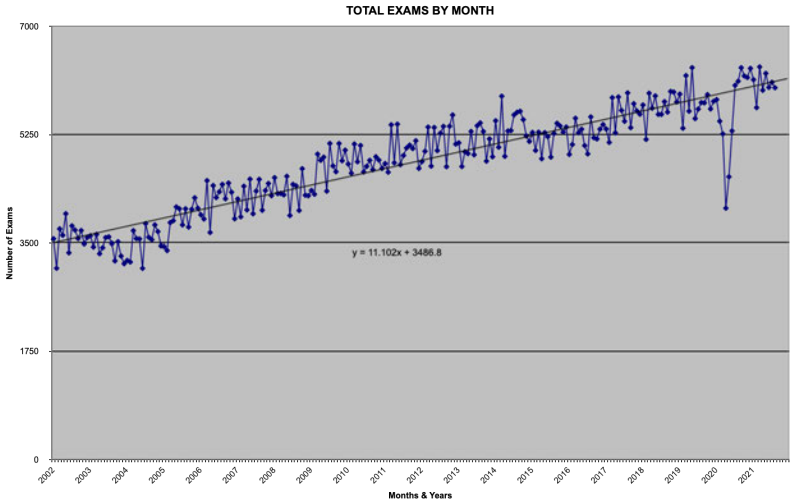
So while it is true that the LGH does not have a 24/7 on-site radiology service, it does have a 24/7 service delivered via a combination of on-site and on-call. Additionally, reporting by Specialist Radiologists for CT and MRI scans is available 24/7 with reports required to be available within 1 hour of receipt of the images.

Activity:

It is worth noting that radiology was one of the fastest, if not the fastest, growing services at the LGH in terms of activity.

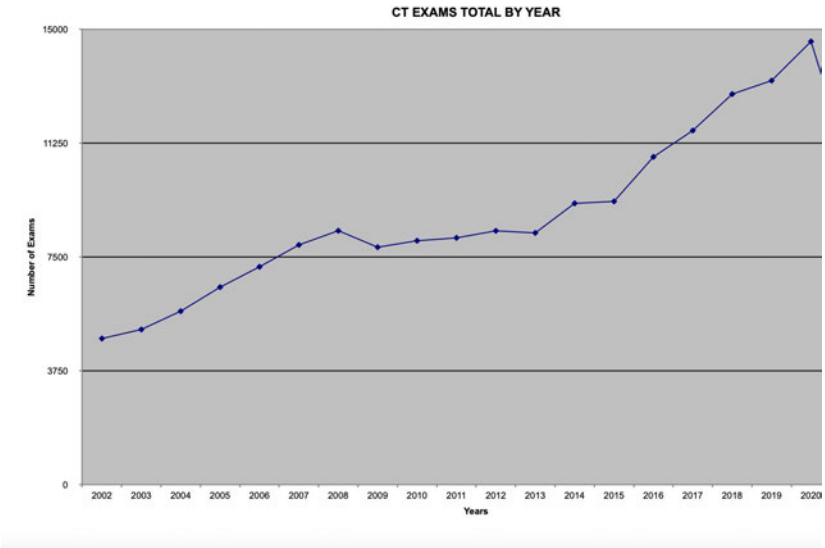
From year 2002 through to 2021 the total examinations performed across all modalities increased from approximately 42,000 pa to over 70,000 pa representing a 67% increase in activity

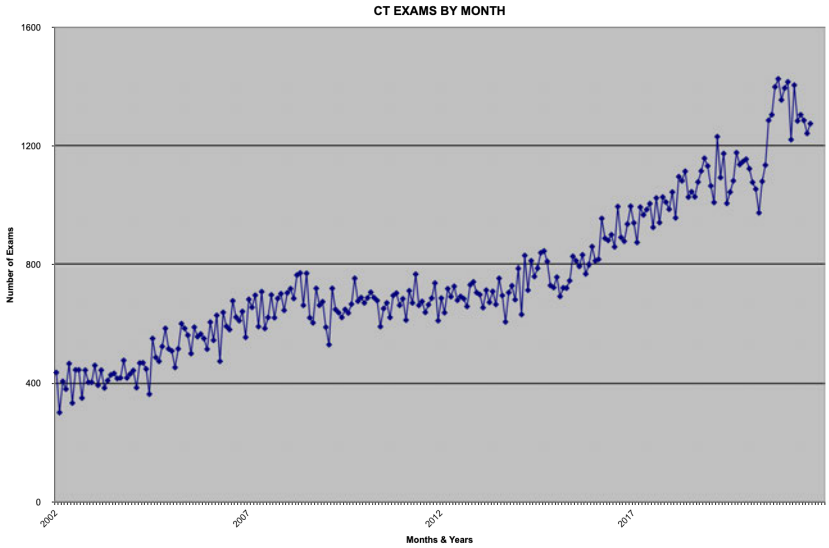




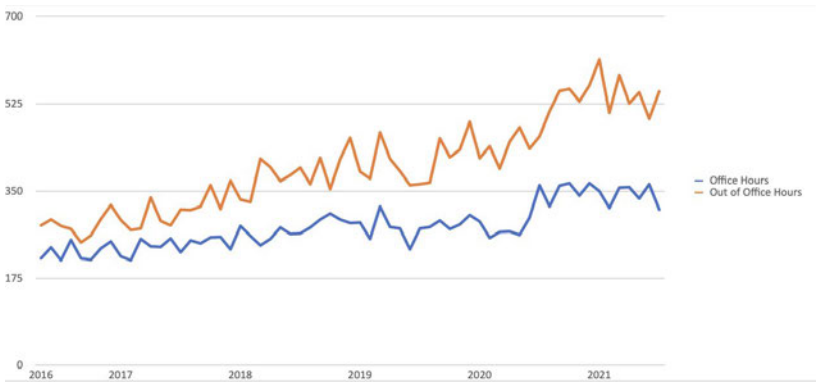
CT Scan:

During this same period (2002 to 2021), CT Scan was by far the greatest contributor to this activity growth increasing 232% from approximately 4800 examinations pa to approximately 16,000 pa. As of end of 2023, my understanding is that, the pa total has increased to approximately 18,000 scans pa.





In the five years (2015-2020) there was significant growth in CT scan activity with an overall increase in scans of 44%. During this same period after-hours activity increased by 49% during weekday evenings and 122% overnight. Weekend activity during the same period increased 37%. *From July 2020 to Sept 2021, month on month activity saw a further increase of 25% compared with the previous year. As noted this activity has continued to increase year on year though to the end of 2023.*



What this comparison between weekday and on-call activity growth for CT scan shows is that providing services on-call does not limit access to this service, indeed, on-call activity growth has outstripped in hours growth.

The key driver for change in CT Scan activity is that it is now a primary diagnostic tool that has become an integral part of the patient management algorithm combined with the increased pressure of emergency department to more quickly assess patients.

So whilst CT Scan is provided by a mix of both on-site and on-call arrangements the activity shows that the service is in effect on-site almost 24/7. The decision to call staff to undertake scans is made by the medical staff. Whilst the protocol was once that call ins were only for urgent cases this has not been the case for many years and any patient needing a CT scan that impacts their management will receive a scan and subsequent report in a timely manner.

For ramped patients, the decision to request imaging, both in hours and on call, is exactly the same; it is decided by the attending medical staff. If the attending doctor requests any imaging such as an x-ray or CT scan then the x-ray or scan is undertaken in a timely manner. The only caveat to this is that in the case of ramped patients there was always constant issues about patients being taken for imaging/scans as they weren't ED patients and they were still often on ambulance trolley stretchers and there was always an issue about if they could be taken for imaging and not. This was a conflict, if you like, between the responsibility of the paramedics caring for the ramped patients and ED responsibility. From a medical imaging perspective if imaging was requested then it would be undertaken, even if the patient was ramped, provided the patient could be transported to the department. As I have not been at the hospital for more than 2 years I am not sure if the conflict in transporting ramped patients for imaging has been resolved. It is my view that the way medical imaging services are delivered through a combination of on-site and on-call does not contribute to ramping of patients at the LGH.

Comparison with the RHH

As of September 2021, the LGH Dept of Medical Imaging operated at approximately 48% the FTE of the RHH department undertaking 75% of the activity. Ultrasound, however, had approximately 48% of the FTE and undertook 85% of the activity. The LGH had 1 CT scanner while the RHH had 2 dedicated CT scanners with access to a third scanner for overflow if needed. One scanner the LGH was performing the equivalent of 75% of the scans undertaken at the RHH on 2+ scanners.

Staffing CT

Staffing for CT Scan was the equivalent to 2 dedicated FTE with a further 1 shared FTE as day workers. This was supplemented by staff in other areas to cover periods of leave and assist with on-call cover. Prior to my departure in 2021, I was able to secure an additional 4 FTE as part of a proposed implementation of a shift roster for CT to extend on-site hours and reduce on-call hours. The rationale for increased FTE and expanding hours of on-site operation was primarily because on-call was not sustainable for the staff nor the department as it operated at that time, and a proposal for a second CT scanner at the hospital. My understanding is that recruitment to these positions has only been partial and implementation of a shift roster is yet to occur. (I will address the second CT scanner proposal below)

What happens at other equivalent hospitals?

The LGH model for delivering medical imaging services is typical of many equivalent hospitals across the country There is variation of models with some delivering, for example, some basic CT services as part of the general shift roster while more complex CT services are delivered on-call. Others have extended on-site hours for CT. Most deliver MRI, Ultrasound and angiography after hours via on-call. Many large tertiary hospitals in

large cities have 24/7 on-site x-ray while some also have 24/7 CT and extended hours for MRI and ultrasound. Some of those hospitals do not have 24/7 on-call for MRI or ultrasound, for example. At the RHH, as of 2021, CT scan operated extended on-site hours via a shift with overnight via on-call

The limitation to extended on-site hours is always staffing. In the first instance there needs to be the required staffing FTE allocation to be able to offer extended hours via a shift roster and, secondly, there needs to be recruitment to those positions which for regional hospitals such as the LGH has always been difficult. Recruitment to the LGH for radiographers and sonographers has always been difficult. The most productive recruitment was through supporting students undertake their 4th year of studies as full time clinical practice who then went on to be employed in the department. Recruiting experienced staff often proved to be impossible.

Business case for second CT scanner

A detailed, comprehensive business case for a second CT scanner was completed by myself in 2020 and submitted to hospital management at the LGH. ***This business case was not progressed past hospital management despite multiple follow ups at the time.*** In 2021, I had a by chance corridor conversation with the Secretary of the Department of Health (Kath Morgan Wicks) which allowed me to brief her on the CT Scanner business case and she asked that I forward the business case to her. Subsequently, on my very last day at the LGH, the Director of Finance DoH called me to discuss the business case and assured me, that despite my departure, that the second scanner would be progressed. My understanding is that a second scanner will finally be installed at the LGH in June 2024, some 4 years since the original business case submission and almost 3 years since my departure. In addition to the second scanner, the current scanner should have been replaced in 2023 under capital sensitivity rules for Medicare but this has not happened and it will now be replaced after the installation of the second scanner.

Why have I raised the activity for medical imaging and other issues?

I have highlighted the activity, specifically CT scan, to demonstrate the growth over time and the pressure the department is under to deliver those services. The growth has occurred with only very limited increase in FTE. Despite this, the department continues to meet the needs of the hospital through a mix of on-site and on-call services. The growth in CT scan has been significant and is not commensurate with any growth in emergency department presentations. The growth has, in fact, far outstripped any growth in ED presentations. The activity, specifically the growth in activity, is not sustainable in my opinion and the hospital management and DoH more broadly needs to urgently review resourcing for the department to ensure that it is sustainable in the future.

I would like to note that, in my 18 years in charge of medical imaging at the LGH, I was <u>not once</u> asked by hospital management or Department of Health to provide data relating to

activity for the Department of Medical Imaging. I was the custodian & program director for the statewide medical imaging IT systems and access to download of data could only be accessed by myself or my IT system administrator. The only time data has been extracted and provided was to an external consultant who was tasked by the DoH to review and audit the delivery of medical imaging services across all of the major public hospitals in Tasmania. This report was delivered in 2020-21. For the LGH, the review found that the department was operating at a standard that was equivalent or better to comparable services elsewhere in the country while in some areas was operating at a level far above equivalent departments. The review, in fact, commended the operation and management of the DMI at the LGH. The review did also note that professional staffing was at a level not commensurate with the activity. I also note that while the Medical Imaging Audit review found that at the LGH medical imaging was on par with national benchmarks, the RHH was an outlier on many metrics.

I raise the issue of the business case for the second CT scanner to highlight what, in my opinion, shows a dysfunction in not only the management of the hospital at the time but more broadly the DoH. That a clinically critical service could be left to operate at a tempo that presented risk and also with other risks (such as no redundancy) indicates, in my opinion, a lack managerial competence and managerial failure.

Conclusion:

Medical Imaging provides an array of services that can not all be delivered on-site 24/7. The claim, however, that the LGH does not have 24/7 medical imaging services is not true. Across key areas there is 24/7 access to medical imaging while there is some limitations on the delivery of MRI and ultrasound. DMI services, despite the on-call component, are all provided in a timely manner.

It do not believe that the way medical imaging services are delivered at the LGH contributes to issues of ambulance ramping at the LGH.

I'd like to thank the committee for the opportunity to make this submission. If there are any queries please do not hesitate to contact me. I am more than happy to meet in person or appear before the committee if that is deemed necessary.

Garth Faulkner
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