PUBLIC

LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY 28 SEPTEMBER 2018

ACUTE HEALTH SERVICES IN TASMANIA

Mr RICHARD CONNOCK AND **Ms PHILIPPA WHYTE**, HEALTH COMPLAINTS COMMISSIONER, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - This committee hearing is being broadcast today. The evidence you are giving today is protected by parliamentary privilege, as you may be aware. I remind you any comments you make outside the hearing may not be afforded that same privilege. I believe a copy of the information for witnesses has been forwarded to you. Are you aware of that?

Mr CONNOCK - Yes.

CHAIR - The committee is being recorded on *Hansard*. A version of that will be published on the committee's website when it becomes available. As you go forward today you have the opportunity to make some opening remarks if you wish and then we can ask questions from there. There is one other matter - it is always on the back and I always forget to do it - which is about in camera evidence. If you feel at any time during the course of the session this morning that you want to say something in confidence, you can let us know. We will consider that and we will go forward from there to make sure that the evidence is in confidence.

Mr CONNOCK - I do not have any opening remarks.

Ms WHYTE - I am the same. We have been invited without making a submission.

CHAIR - For the record, could you explain your role? It would be good to get an understanding of the breadth of what it is that you do and the types of complaints you receive.

Mr CONNOCK - We can both answer that. I am the commissioner but as you know I have a number of other functions as well. I am also the Parliamentary Ombudsman, the Energy Ombudsman, the de facto Information Commissioner and the Custodial Inspector. I wear a number of hats. I rely very heavily on principal officers in each jurisdiction because I am spread a little bit thin over them. Pippa is the principal officer of the Health Complaints jurisdiction. She is the one who is responsible for the day-to-day operation and the nuts and bolts, if I can put it that way without belittling the position at all.

We take complaints from health service users against health service providers in both the public and the private sector. We look more at system issues than professional practice since the introduction of the Australian Health Practitioner Regulation Agency in 2010. They look at questions of professional practice. If we have a medical practitioner and the allegation is of malpractice, putting it very broadly, that goes AHPRA.

We can keep part of that complaint or it can come back to us if there are also systemic issues or if it is something we can resolve by way of conciliation. Pippa is our accredited conciliator.

Ms WHYTE - It is has just lapsed.

Mr CONNOCK - The only one we have unfortunately so we are not doing it as much as we could be there. We tend to look at the system issues and the object of the exercise is to improve the provision of health services. We do that by way of complaints primarily so we are looking at individual complainants and also we have our own motions.

Ms WHYTE - Although we look at system issues under the legislation, we have a resolution focus. We are not set up as a watchdog, as in 1995. It is very much along the lines of don't investigate if it will get in the way of conciliation. There is a focus on resolving the complaint between the provider and the complainant. I suppose it is attention. Certainly other jurisdictions are looking at absolutely at doing the investigations into the systems and we are not.

Mr CONNOCK - If you look at the second reading speeches partially an alternative to suing for medical negligence or so forth but the idea, as Pip says, is resolution. We are very focused on trying to resolve that. We are not advocates for either party obviously, but if there is an issue we will try to resolve that.

Ms FORREST - By bringing the parties together?

Mr CONNOCK - Yes. That is the preferred method. We get a complaint, we have a period in which to assess it and we can dismiss it, refer it for investigation or refer it to conciliation or the registration board. If we are keeping it, they are the three things we can do with it.

Ms WHYTE - We can split a complaint and we can have any combination of those. It might be that we refer some practitioners to AHPRA and the registration board, and we conciliate the issue between the parties and potentially we could investigate system issues. We also try to get resolution with any system issues from the conciliation process. If a hospital has already made changes because something went wrong, it seems a bit ridiculous for us to investigate what they have already committed to do and change.

CHAIR - Your work it not confined to things that happen within the hospital; it is across the whole scene, isn't it?

Mr CONNOCK - In the health service, which is fairly broadly defined.

Ms WHYTE - It is very broad because it can cover disabilities, not that people know that because it is not in the title.

CHAIR - What number of staff do you have to deal with these? Are you able to give us some metrics on how many you deal with over the period? Is that possible?

Mr CONNOCK - We are finalising annual reports at the moment, so these figures will be coming out in an audited form soon. Not over the same period. Pip has done a survey over a 10-year period. There will be figures coming out in the annual report that show the exact numbers of complaints.

CHAIR - A broad understanding would be fine.

Mr CONNOCK - It is interesting. I will show you this and I will not hand it over because the numbers are not finalised. The trend over the past 10 years is that complaints have increased. There has been an upward trajectory the whole way through.

Ms FORREST - In all areas?

Mr CONNOCK - This is only health. It has been the same in other jurisdictions but we are only talking about health today.

Ms FORREST - That is fine. I wanted to clarify you are just talking about health.

Mr CONNOCK - There has been a steady increase in complaints over time, and over the same period the number of people we have to deal with it has decreased for various reasons. In 2007 our establishment was 6 FTEs, now it is down to 4.2 FTEs.

Ms FORREST - Have you made representation to the Government about your resourcing?

Mr CONNOCK - I have over the years made several representations about resourcing. It is a constant issue. It is not confined to health. I have two particular jurisdictions that are problematic with resourcing and I have been asked at Estimates about RTI several times but health is the other one. Both are in the same position - we get a steady number of complaints and we are able to deal with the complaints we are getting in the sense that we are closing about as many complaints as we receive in a reporting year, but we have an historical backlog.

CHAIR - How large is that backlog?

Ms WHYTE - This year it was a carry-forward of 150 and we were not able to close nearly as many complaints as we received.

Mr CONNOCK - We have had vacancies this year.

CHAIR - Delivery times are extending?

Ms WHYTE - Delivery time are extending.

Ms FORREST - What is your statutory time frame?

Mr CONNOCK - We have 45 days which can be extended to 90 days or we can suspend almost indefinitely if we are waiting for information from somebody else - that is, if the delay is not down to us, if we sought information from someone else and we are waiting for that to come back.

Ms WHYTE - That statutory period is to undertake an assessment, which is generally making a decision about whether we are going to investigate, conciliate or dismiss. The fact is, because we are waiting for information or because of investigation and conciliation, we try to do some informal resolution within assessment so it does not require the more formal processes and we frequently go above the 45 days because we are trying to do more in that assessment phase.

CHAIR - What impact is that having on the cases themselves with time frames that are extended as circumstances change? How has it impacted in that sense?

Ms WHYTE - I think what is happening is that we have this constant flow of simple lower-level complexity cases. For example, over 10 years they have gone from approximately 109 up to 232. -

Ms FORREST - Per year?

Ms WHYTE - Per year, yes.

Then we have a steady flow of what we call 'intermediate cases'. They have gone from 80 to 103, so it remains fairly flat. The complex cases usually sit around the mid-20s to 30. Complex cases would mean an episode of care involving numerous practitioners - lots of things potentially going wrong.

Ms FORREST - Not necessarily the outcome for the patient?

Ms WHYTE - No, complexity is not about the outcome for the patient. It might be but it might -

Ms FORREST - If they had multiple admissions with multiple complications and things like that.

Ms WHYTE - One episode of care going in - it is not fair to say it is all about hospitals but they are the easier ones to give examples about - through accident and emergency and they emerge out of rehabilitation at the other end, having had some form of surgery or something, then there might be a number of issues. It does not mean necessarily that something has gone wrong; it is the belief that something has gone wrong or it might just be that they are terribly unwell.

CHAIR - So that expanding length of time presents its own administrative issues then for you, having to communicate with those making representations?

Mr CONNOCK - Exactly. As Pip said, if you have numerous personnel involved, they will have to be consulted in relation to a response. That can be difficult, and without blaming anybody, practitioners move on. They go on sabbaticals and take holidays, which they are entitled to, so there is often a delay there. Also, when we refer it can take a considerable amount of time for it to come back to us from that referral. Of course, whatever AHPRA decides will inform what we are going to do.

Ms FORREST - I have a couple of points. The increase, particularly the less complex cases, I guess, may take a little less time to resolve potentially. We have heard from a number of other witnesses -and we have seen in the media every day almost - the increase in ambulance ramping and delays with the patients sleeping on the floor and being three, four or five days in the Department of Emergency. Do you see any correlation between complaints of that sort and the apparent more recent increase over the last few years?

Ms WHYTE - I was trying to think whether all those things we hear in the press actually translated into an increase in complaints to us. I think, given the number of episodes of care versus the number of complaints we get, we get a very low number of complaints. If we are

talking about only 60 or 80 per year about, say, the public hospital or something like that, there was a bit of a spike in the last 12 months about complaints about public hospitals.

Ms FORREST - Particularly in relation to the Department of Emergency Medicine, or was it broader than that?

Ms WHYTE - No, not necessarily.

Mr CONNOCK - As we all know, the hospital itself has been disrupted this year. I am not saying that is the reason for the spike in complaints. We were looking for specific things across the board to see if we could find any particular pattern but there is not. I could volunteer an explanation for complaints against the institution - I do not know whether it is true or not.

Ms FORREST - Against your institution?

Mr CONNOCK - No, against the Royal. If we get complaints about that, I could say it is under construction, there is upheaval, beds are limited, all that sort of stuff, because of the circumstances now. I can surmise that might be a reason complaints might have increased, but I cannot say with certainty.

Ms WHYTE - I think if someone were to ring and say they are on the waiting list and are they not being seen quickly enough, it is unlikely we would take that as a complaint. We would probably say 'It is the nature of waiting lists; go back to your GP.' We would deal with it as an inquiry. We get roughly 400 inquiries a year about these complaint levels that are matters we just deal with and do not actually take on as complaints.

Ms FORREST - Can I go back then to when you made the comments about your staffing levels a few years ago and now? Obviously, the complaints in all categories have increased; your staffing levels decreased; and we have recently passed some legislation to give you more work in terms of -

Mr CONNOCK - We are horrified.

CHAIR - Are you aware of that?

Ms FORREST - I do not know if you were watching the debate, but this is a matter of great concern to me.

Mr CONNOCK - I have read the debate. I did not watch it.

Ms FORREST - You were not consulted about that?

Mr CONNOCK - I have been in contact with my counterparts interstate. New South Wales, South Australia and Queensland already have codes. I have been speaking to them about the impact on their offices of that. I have been to see the Secretary of the Department of Health and Human Services, and I have been to see the Attorney-General. They are aware this is potentially a difficulty. We do not know how big it is going to be down here; that is the problem.

Ms FORREST - Do you have any indication? APHRA deals with doctors, nurses, physios, paramedics - I think it is 15 now categories. Those people go through fairly rigorous training and

have a whole heap of legal training in terms of compliance with the relevant legislation. APHRA deals with complaints about people who are generally more educated in their field. Some of the occupations that will now be required to consider complaints or potential breaches of the code do not have that same level and almost can hang up a shingle and say 'I am a whatever'.

What has been the experience in other states and how do you think it is going to impact on you? I cannot see how the Health Complaints Commissioner can possibly deal with this because of the challenges you are already facing. I think there is a case here. Can you explain to me what you think is going to happen and what needs to happen?

Ms WHYTE - There is no question we are going to have to bring a lot more rigour to the investigation based on the fact it has the potential to impact on someone's employment.

Mr CONNOCK - As I said, we do not know what it is going to be like here. I can tell you what I have been told by our counterparts in other states, which is perhaps not directly referable to the Tasmanian environment. I don't know. In New South Wales, for example, the health complaints entity gets thousands of complaints every year.

Ms FORREST - In this area?

Mr CONNOCK - No, comparatively few in relation to unregistered practitioners. The difference is, as you have said, that the others have registration boards. You can refer those complaints back to the board. There is no board here so the entity has to deal with it and it has to stay there. As Pip intimated, we can issue prohibition orders, we can deprive people of their livelihood, so it is a fairly significant thing.

CHAIR - It has to be done properly, doesn't it?

Mr CONNOCK - It has to be done properly. What I am told by people in other states is that you need people with legal qualifications because you are actually prosecuting a case. It is not like an administrative investigation, which we do in Health, Ombudsman or Energy; you are more prosecutorial. You need someone who knows what they are doing and who knows how to draft an order and how to justify an order.

Ms FORREST - You do not have those skills in the Health Complaints Commissioner at the moment?

Mr CONNOCK - We have a couple of legally qualified people but they are not used to doing that sort of work. It is a different approach.

Ms FORREST - Practising law is not just practising law, as I am sure most people understand.

Mr CONNOCK - Exactly. We have a number of legally qualified people who have not practised and there is a big difference there.

Ms WHYTE - I am a lawyer by background with tribunal experience. I have sat on three tribunals. The time that will need to be dedicated to these cases, even if we get just two to get started -

Mr CONNOCK - They can be significant.

Ms WHYTE - If you take one person off doing that, you have almost halved your workforce at the moment.

Ms FORREST - With your current workload and trying to deal with the backlog - and I understand some cannot be dealt with until other information is received - how many staff do you need compared to what you have now and how many do you think you will need to deal with the legislation we just passed to deal with the backlog?

Ms WHYTE - It is very difficult to know because we do not know how many we are going to get in the first instance. I think you can go back two years, potentially. Are we going to get an influx of what has happened in the last two years? I am not sure. We are not quite sure what -

Ms FORREST - Without trying to project, what would you need now to make it work effectively?

Mr CONNOCK - If we go back to the six FTEs, we were productive. Reports were getting done; things were being conciliated in a timely manner -

CHAIR - Time frames were being met.

Mr CONNOCK - Yes, they were being met. We had the Global Financial Crisis and various other factors that meant a significant cut in funding across the board, but Health has been affected by a loss of effectively nearly two FTEs or 1.8.

Ms FORREST - And your work has not decreased.

Mr CONNOCK - No, it has increased.

Ms WHYTE - The complaints have gone from just under 200 to over 350.

CHAIR - Do you have a regional split on that?

Mr CONNOCK - We can by hospital. Again, these are not firm figures. If you look at the graph - the Launceston General and Royal Hobart hospitals - the major population areas are the most significant. There are still complaints from North West Regional and so forth.

Ms FORREST - I am sure there are because a lot of them come through my office.

Ms WHYTE - Talking about those complaints, that is everything - it is individual practitioners, registered practitioners and unregistered practitioners. When we get a complaint about an unregistered practitioner, we can try to resolve it but we don't have a role in relation to conduct and performance until the code of conduct comes through.

Mr CONNOCK - As you have probably seen interstate, the issues with unregistered practitioners can be particularly serious. There one in Queensland with an anaesthetic technician who was pinching fentanyl and replacing it with water, which is potentially dangerous. There have been a number of episodes in New South Wales of body sculptors - people having horns

implanted. We effectively have tattoo artists administering anaesthetics. A young woman died of sepsis as a result of one of those procedures earlier this year.

Ms FORREST - That is right. There is also the risk of sexual assault with a masseur and things like that, which -

Mr CONNOCK - There are botox clinics in hotel rooms on the Gold Coast. We don't know what is happening -

Ms FORREST - It definitely needs some form of regulation. I am concerned that -

CHAIR - It's the capacity to deal with it.

Ms FORREST - That is right. Where is the capacity?

Ms WHYTE - Another concern is how wide is this definition of health service going to be? At the moment, for something that might be cosmetic, the issue is: is that a health service and where do we draw the line there? That will need to be clarified.

Mr CONNOCK - There is going to be a bit of bedding in.

Ms WHYTE - Something that might improve your appearance, might improve your therapeutic whatever, and it might be considered health -

Mr CONNOCK - That might have a therapeutic remedy as well.

Ms WHYTE - but it might not be a health service. Our current definition is very broad and that is probably something that will to be nutted out in the regulations.

CHAIR - I have a question about your budget. I know this is an acute health services inquiry, but anything that impacts on acute health services is of interest to us. The FTEs you have at your disposal is one issue, but in general terms with your budget, do you have to buy in certain legal services to cope with certain cases and what has been the impact over time?

Mr CONNOCK - We have a clinical consultant, speaking of health, to deal with that.

Ms WHYTE - We have a budget for that.

Mr CONNOCK - We're not clinicians.

Ms WHYTE - Prior to that we used to approach the individual registration boards for informal clinical advice because we didn't have a clinical budget. With AHPRA, national laws coming have distanced us from the boards, with the AHPRA a bit in between. It is vital we have this clinical advice.

CHAIR - How do you see that? Is that running very thin?

Mr CONNOCK - The problem is not so much with that. That seems to be working quite well. We have a clinician coming in on a regular basis and we have a budget line for that, so that is covered. The problem is, going back to what we are saying before, that we are just dealing with

the stuff coming through the door on a daily basis. We are unable to address the backlog in a timely manner. One of the things I said before, is that Pip is - I think she is still accredited - the only conciliator responsible for that. We were using an outside conciliator for some, but that was not always suitable because they come backwards and forwards.

Ms WHYTE - If, for example, you were negotiating a financial outcome, that would come back to me to end up having to deal with it anyway.

Ms FORREST - Have you sought additional funding in next year's budget to at least manage the code of conduct for unregulated health service providers?

Mr CONNOCK - I think we put in the budget for that.

Ms FORREST - We will have to wait until next year's budget to have that confirmed.

Ms WHYTE - My understanding of the debate as I heard it was that the expectation is that New South Wales only got 11, and it won't be a large impost. The important distinction is that we are not doing that type of investigation currently whereas New South Wales does because they are co-regulatory and are already in that investigation space. We are not.

CHAIR - It is a bit of unknown.

Mr CONNOCK - It is a large unknown.

Ms FORREST - It is not only that, as you described, it is also the skills you need to manage these complaints when they come in. It is potentially a different role.

Mr CONNOCK - As Health Complaints Commissioner I don't have any coercive powers. I can't make anybody do anything. Once this code comes in, I can issue a prohibition order preventing somebody from practising.

Ms WHYTE - More frightening is that we can issue an interim prohibition order, which is valid for 12 weeks and which means we have to complete the investigation within the 12 weeks. I think we can extend it.

CHAIR - The legal information you would need would be significant.

Ms WHYTE - If we were, the impost on the work we are currently trying to do would be huge.

CHAIR - I wanted to explore that side.

Mr CONNOCK - I have spoken to you at Estimates and it is exactly the same with RTI. We can deal with what is coming through -

CHAIR - RTI for *Hansard*.

Mr CONNOCK - Right to information. We can deal with incoming matters but we have historical backlogs in both jurisdictions and, particularly in health. These are important issues for the complainant, the people involved - while it might not be affecting their ongoing physical

health, it affects them emotionally. They have a lot invested in these things. We try to get them resolved as quickly as we can but for various reasons, and it is not just lack of resources, as we said - such as waiting for information to come back from other people and difficulties in the health system while it is being restructured over the last period of time -

Ms WHYTE - The patient safety -

Mr CONNOCK - That is right. Pip has spent a lot of time working up a network of contacts -

Ms WHYTE - The patient safety section had local ones in each of the three areas and with THS that was dismantled and centralised in Launceston. I think people left various positions. Now a lot of positions are empty and there is no-one to talk to. They are trying to re-establish that.

Mr CONNOCK - Yes, we have positive feedback now. Pip has met with people and we have a flurry of activity with stuff coming in.

Ms FORREST - I hope that will help progress some of those that are sitting on your books.

Ms WHYTE - It has been a problem for the last 12 months. When you were talking about increased levels of complaints against, for example, the Royal Hobart Hospital, one of the themes that came through is that maybe the internal complaint resolution process was not working terribly well and people had come to us. Our legislation requires people to go back to the provider in the first instance and try to resolve a matter themselves. If they can, that is where is should be resolved.

Mr CONNOCK - We think it is appropriate the provider has the opportunity to try to resolve it. Sometimes people will not go the provider; they will come to us and, when we contact the provider, they don't know about that.

Ms WHYTE - The change in structure did not help with -

Mr CONNOCK - We have seen improvement there recently and Pip has been meeting with people.

CHAIR - One question on things you see as roadblocks. Are there any things you see holding you up in performing your function through no fault of your own?

Ms WHYTE - Waiting for responses and then consult -

Ms FORREST - Is a particular group difficult in that?

Ms WHYTE - Probably, as I mentioned, but I am hoping that is going to improve. With THS as it was, with staff absences within THS and the people on the ground obtaining the responses and feeding them back to us, there was a lot of movement, many people left and many people have been recruited into positions. I don't know whether they are going to stay, but it has been addressed since July, and people are gradually moving back into those roles. I think you have had submissions about the patient safety area.

That was one roadblock. We have another one, which is the requirement to consult with AHPRA about any registered practitioners. I don't know whether it has had its own difficulties there, but there has been a long time lag. Consultation in its simplest form is that we gather information and make a preliminary recommendation, and then we expect some sort of response. This is all happening within our 45-day assessment period, which is blowing out to a lot more than that for these reasons. I noted recently that sometimes we have had two-, three-, four- or five-months delay in getting a response and then similar delays in the consultation process.

I had meetings recently and there has been a supreme effort -

Ms FORREST - With AHPRA?

Ms WHYTE - Yes, to try to address that.

Mr CONNOCK - They have been good, but it is a two-edged sword. Once you get the other side organised, all of a sudden there's this -

Ms FORREST - You get a wall of information.

CHAIR - That means more work.

Mr CONNOCK - Exactly, and it all comes in at once.

Ms WHYTE - The delays impact on the person making the complaint, but there is a huge amount of research on the impact it has on practitioners While they are going through this.

Mr CONNOCK - That cannot be underestimated.

Ms WHYTE - I have had approaches from three medical defence associations concerned about the impact on their members because of these delays. I met with some of them last week. We are endeavouring to try to do it better, but it is really hard.

Mr CONNOCK - It is system issues. When you talk about roadblocks, nobody is trying to hold things up. It is an organisational issue.

Ms WHYTE - You could say now with all this information that I am the block because I have so much information in front of me, and I am here.

Ms FORREST - That comes back to a resourcing issue.

CHAIR - I was talking about you as an operational unit, not within the -

Ms FORREST - That comes back to a resourcing issue, in that if you are the only person there who can deal with this, it becomes single person-dependent. If you get sick or take annual leave, which I believe you would be entitled to, it appears to me that the office is understaffed, not because you have chosen to understaff but because the money is not there to staff it adequately to meet the demands of the organisation at the moment. Is that a fair comment?

Ms WHYTE - I would agree with that.

Mr CONNOCK - I think that is probably a fair comment.

Ms FORREST - The Health Complaints Commissioner is very important, particularly in terms of our term of reference regarding adverse patient outcomes. Patient complaints, or people who receive health services who make complaints, often lead to recommendations that change practices that help other people and prevent further adverse outcomes, even deaths. So we cannot underestimate the importance of a timely process here. In your ideal budget submission and using a reasonable guess for the work you are going to have to undertake with the unregulated health care service providers, what would you say - not in dollar terms but in FTEs and expertise - you need?

Ms WHYTE - Our establishment is currently 4.2.

Mr CONNOCK - As I said, when we had six it was performing quite well.

Ms FORREST - But the demand has increased since then.

Ms WHYTE - Yes, that is right.

Mr CONNOCK - Even so, that would be a massive improvement - two more people. It would be very difficult to say in relation to the unregistered practitioners. I have spoken to South Australia, for example; it has fewer than New South Wales but accounted for a third of his budget, he said.

Ms FORREST - In South Australia, do they have the capacity to issue prohibition orders as well?

Mr CONNOCK - Yes. New South Wales, Victoria, Queensland and South Australia already have codes.

CHAIR - In terms of the work you are doing now, without getting the codes involvement, how do you sit with other states?

Ms WHYTE - In terms of staffing levels?

CHAIR - Per capita.

Ms CONNOCK - It is a bit like apples and pears.

Ms WHYTE - It is a bit, but we have always been regarded as poor relations. I have been going to these managers' meetings for 10 years, which is my colleagues for that level - not the commissioners - but it has been, 'Pip, why are you still doing this?' It is apples and pears or apples and oranges, as Richard says, and you cannot benchmark. I could say Northern Territory is another small jurisdiction and it has far fewer complaint numbers than us. They count issues rather than complaints and they have a full-time commissioner, a full-time deputy commissioner; I think they have three full-time senior investigation and conciliation officers and probably a 0.5 business manager and an administrative person. I do not know what that adds up to. They have not yet taken on code of conduct. These figures are probably a bit rusty, but I think it was last time I looked at their annual report, and they complain about resources. There are many other obligations or duties of the commissioner they cannot do, such as educating people on complaint

management so providers are better able to manage the complaints internally. Outreach - there are many people who do not even know we exist. We do not want to attract them because we cannot do the work, but we need to attract them. People with disabilities - we had a meeting -

Mr CONNOCK - Yes, we have disabilities and we met with Population Health Services recently to gather data about Aboriginal and Torres Strait Islanders; they have been holding forums about Indigenous health and no-one had heard about the Health Complaints Commissioner.

Ms FORREST - Really?

CHAIR - That is unbelievable.

Mr CONNOCK - We have had disability -

Ms FORREST - The floodgates could open further once people know.

Mr CONNOCK - Well, they might. I do not know how many complaints there would come from people who identify as Indigenous.

Ms FORREST - I guess in many respects in Tasmania Aboriginal people tend to access services that non-Aboriginal people also access, so they will come through the same doors effectively. There are some that provide particular services that are Aboriginal services.

Mr CONNOCK - Yes, we were a bit surprised about that. As Pip has said, disability is covered by the definition of a health service, most of it is, but because it is not in the title, people do not know that we can do that.

Ms FORREST - For my benefit as much as anything, if people have a complaint regarding the NDIS and access and service delivery through that, does that go to the Commonwealth Ombudsman?

Ms WHYTE - Yes, if it is an NDIS matter, but there are people who are not NDIS-funded. It has to be a health service to come within us. It has to relate to the health and the therapeutic so they cannot complain that the taxi did not turn up or about the house cleaning. The therapeutic aspect of disability we can look at. We are not sure - even the disability commissioners are not sure - what will be left after the NDIS commission is set up. There are other really important issues that relate to people with disabilities going through our public health system, and I am aware you had submissions from Professor Wallace. It is really important to look at stuff like that.

Ms FORREST - Those people themselves often are unable to make the complaint. It is often a carer or a family member who does it on their behalf.

Ms WHYTE - It is well known or well accepted, and it is a theme we have heard because when I attend the managers' meetings many other entities are health complaints and disabilities. The theme is that people with disabilities or their carers do not like to complain because the concern is that it is going to impact on. You have to go out and find them and it is those dark corners, I suppose, that maybe you are not finding.

Ms FORREST - Sometimes these people come to members of parliament and we can direct them to the process.

CHAIR - Mental disability, mental health?

Ms WHYTE - In terms of complaints that come to the Health Complaints Commissioner, because Richard is also the chief official visitor for mental health -

Mr CONNOCK - Another one I forgot.

Ms WHYTE - and the prison we have a robust official visitor program.

Mr CONNOCK - We coordinate the mental health official visitors - OVs - and the prison official visitors.

Ms WHYTE - I think matters that might otherwise come to the Health Complaints Commissioner get dealt with probably at that -

Mr CONNOCK - The mental health OVs do not have extensive investigative powers but they can deal with things on the spot. If a patient raises an issue with them, they can speak to the nurse unit manager or whoever is around and try to resolve it on the spot, and a lot of that sort of thing.

Ms FORREST - Which is a much better way to do it.

Mr CONNOCK - Absolutely, yes, without escalating things. These people do not want to be involved in some big bureaucratic procedure.

Ms FORREST - It is not good for their mental health.

Mr CONNOCK - No, they just want a result.

CHAIR - Do other states have commissioners who have the same hats to wear?

Ms WHYTE - In Victoria they have a mental health commissioner, a disability commissioner, a health complaints commissioner and an ombudsman. They have four separate people.

Mr CONNOCK - The same in Queensland. In New South Wales, the Ombudsman is a huge office and they have several deputy ombudsmen. There is a separate health complaints commissioner but one of the deputy ombudsmen is the de facto disability commissioner. In New South Wales, they also have reportable disability issues and they also review deaths of people with disability.

Ms FORREST - Like a coroner?

Mr CONNOCK - They review the deaths. Western Australia has the function in relation to deaths of children in care as well, but New South Wales extended it to children and young people and people with disability. They do a yearly review.

Ms FORREST - Like a coronial inquiry?

Mr CONNOCK - They do not investigate, they review it. Review it and report on it.

Ms WHYTE - I think for it go before the coroners, it has to be unexpected and probably some of the deaths of people with disability saying it is not unexpected because they had a disability. But the question is, was it?

Ms FORREST - The disability they died from or some complication?

Ms WHYTE - I think that is the blur, and I think that is potentially what -

Mr CONNOCK - That is what Associate Professor Wallace was talking about in those reports. It is an important thing, and we would love to be doing that sort of thing. Another aspect of this is that it is not just the complaints - we do come across issues. We have an own-motion function as well to investigate something non-reliant on a complaint. That is often the best way to do bigger issues because you are not dealing with the expectations of an individual. You are looking at it in the abstract. We simply can't do that at the moment. We have several waiting in the wings but we can't do that -

Ms FORREST - You have the capacity but you don't have the resourcing.

Mr CONNOCK - Yes.

CHAIR - Is there anything in particular you would like to bring to our attention in relation to the performance of your role and acute health services?

Ms FORREST - The reason the committee was keen to hear from you is because we've been hearing many personal accounts of what was considered by people to be poor service delivery or problems with service delivery. A number of these people had interacted with the Health Complaints Commissioner office and some are frustrated by delays and things like that. We thought it was really important to hear from you because the work of the commission can have a really positive impact on the delivery of health services: how you deliver the work you do and what you need to do it well. If there are delays that aren't due to waiting for information or relating to resourcing, that is something the committee can comment on.

Mr CONNOCK - Some of those delays are definitely due to resourcing.

Ms WHYTE - Without question. Unfortunately, we have had people away on illness and because of annual leave and things.

Mr CONNOCK - If one person goes, a quarter of the workforce is gone.

CHAIR - It is also important for us to understand the hold-ups of information flow from the acute health services system to you in your performing your role.

Ms FORREST - You talked about AHPRA being a bit tied up at one stage, but now the information is flowing in a bit of a torrent.

Ms WHYTE - I think the movement in AHPRA was that the state manager became acting state manager in another state -

Mr CONNOCK - In the ACT as well.

Ms WHYTE - The manager of notifications, director of notifications, became the acting state manager and everybody moved up a notch and there also was an overlap. They have created these groups. The people in Tasmania also deal with the notifications in ACT. There is a lot of movement.

Ms FORREST - Do they?

Ms WHYTE - I'm not sure what they are. They are sort of groups and they deal with -

Ms FORREST - Small jurisdictions probably makes it more efficient.

Ms WHYTE - They do some of the less important work for New South Wales because New South Wales deals with -

Ms FORREST - So much.

Ms WHYTE - The Health Complaints Commissioner in New South Wales deals with the serious matters and the less serious matters go to AHPRA; it is the different way around.

Mr CONNOCK - That is something that probably should be noted, too. Different jurisdictions have a different relationship with their local AHPRA branch.

Ms WHYTE - In New South Wales, the Health Care Complaints Commissioner deals with health conduct performance and the less important matters go to AHPRA. We're the same as Northern Territory, South Australia, Victoria and Western Australia.

Mr CONNOCK - An MOU was developed when AHPRA was first established and we still work to that MOU.

CHAIR - Is there much interaction between commissioners across Australia about process and those sorts of things?

Mr CONNOCK - Yes, the commissioners meet twice a year and it is always interesting. We are a very small jurisdiction and some are very large but we all have very similar issues.

CHAIR - You can learn from each other, obviously.

Mr CONNOCK - Yes, it is a very valuable forum and also in the networks that are established. I can email every commissioner in the country and ask, 'Have you ever come across this?'. I will have answers within minutes.

CHAIR - In a sense it is a resource.

Mr CONNOCK - It is an incredibly valuable one. Unless you have worked in these areas you don't really know how these systems work. I am being very generic here. It saves a lot of

time and effort if you can tap into somebody who has done this sort of stuff before. It is an incredibly valuable resource and Pip has this, too, at the manager level.

Ms WHYTE - We have a managers' meeting annually. Just with the code of conduct work, Victoria is ahead of us because they had a legislative review. The code of conduct is already part of that legislation and they will then adopt the national code. They are already, in the last 12 or six months, issuing prohibition orders. They share the orders with us so we are aware, and this is what is going to happen down the track. There is going to be a joint website where all prohibition orders for unregistered healthcare workers can be noted. It is interesting; I have had four or five come through in the last five months. My plan is to speak to the people there and find out how they are doing from what they are doing.

Mr CONNOCK - We have a commissioners' meeting in November and New South Wales and Victoria are going to present on dealing with these matters and share their knowledge.

CHAIR - Is the legislation you each have relatively comparable?

Mr CONNOCK - Broadly.

Ms WHYTE - Queensland, New South Wales and Victoria have more of this watchdog role. We were modelled on the old Victorian legislation, which is resolution. You resolve before you investigate, not a lot of teeth.

Ms FORREST - Do you think it needs to change?

Mr CONNOCK - No. It is probably a good model if it were properly resourced. The act needs review and it has not been looked at for a long time. It was supposed to have a statutory review after five years.

Ms WHYTE - It was meant to be three years and then every five years thereafter. That section disappeared.

Ms FORREST - Are you talking about the Ombudsman Act?

Mr CONNOCK - No, the Health Complaints Commission is supposed to be reviewed. It could probably stand it. It has been around since 1995. There are a few bits and pieces -

Ms FORREST - There is a process in the majority of the states, with the MOU with AHPRA, but New South Wales do it differently -

Mr CONNOCK - And in Queensland.

Ms WHYTE - That is because the commissioner has the mandate to deal with the health conduct performance of the practitioner.

Ms FORREST - Is there any likelihood it is going to change? If the Health Complaints Commissioner has to look at the more serious complaints and the less serious complaints go to AHPRA, I would have thought it would have been the other way around.

Ms WHYTE - With the MOU, New South Wales weren't a party to it and it was prior to the Queensland Health Ombudsman being established. They have changed. The ACT does it a different way because when the legislation was adopted into ACT, they ensured there was a joint consideration of cases between the commissioner and the boards. Whereas in the remaining states, we all operate in a similar way - and this is only in relation to registered practitioners.

CHAIR - Thank you very much for coming in. It is very much appreciated you have taken the time. Is there anything else?

Mr CONNOCK - No. We were invited here to answer questions.

Ms FORREST - We appreciate you coming because it is a really important aspect of the inquiry.

CHAIR - Yes, it is good. Thank you very much. To remind you, anything you say outside this room is not afforded parliamentary privilege.

THE WITNESSES WITHDREW.

Mr SCOTT RIGBY AND **Mr ANDREW BRAKEY**, ANMF, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - This is the Legislative Council Administrative A Subcommittee Inquiry into the Acute Health Services in Tasmania. Just to clarify, it is not something the Government has brought on; it arose out from one of the administration committees of the Legislative Council. I noticed in the paper the other day that it was stated it was a government inquiry.

Ms FORREST - They often get it wrong.

CHAIR - I just want to make sure you are aware of that. All evidence taken is protected by parliamentary privilege, but if you walk out the door and talk to the media, that may not be the case. We are recording the hearing today so it will be on the *Hansard* website. There is information for witnesses, which you should have been provided a copy of. Are you familiar with that?

Messrs RIGBY AND BRAKEY - Yes.

CHAIR - Okay. The opportunity is there for you to make some opening comments. Before I hand over to you, if there is anything that you wish to say that you feel is confidential or needs to be in camera, please alert us and we can have discussion and it will go forward from there. Over to you for any opening comments and then we will have some questions following that.

Mr BRAKEY - Thank you very much for the opportunity today.

I have some opening comments that give a bit of context to Scott's evidence today as far as to what the situation at the LGH is. We are currently of the opinion at the Australian Nursing and Midwifery Federation - ANMF - as are our members, that it is the inadequate funding supplied to the Tasmanian health system by the Government that is causing the issues in the emergency departments across the states.

These budget constraints are not only putting the nurses and midwives working within the system at risk, but also the patients. It is documented clearly on the Tasmanian Health Service risk register that the LGH bed block is an extreme risk. However, lack of funding in the system and budget constraints in the service are hamstringing the THS in dealing with it. This is a an emergency department where, through no fault of the staff working to their full capacity to care to the members of the public presenting to the department for treatment, waiting times are the worst in the country.

In line with Scott's evidence today, a specific example of where the LGH budget and best practice has been overridden because of the budget: Ward 4K has four beds available to be opened, which are benchmarked for staffing but no recruitment processes have yet been undertaken because of budgetary constraints. The ICU has beds available at the LGH. However, if they opened those beds, they would need to employ extra medical professionals and so, because of budget constraints, those beds have not been opened.

CHAIR - How many beds there?

Mr BRAKEY - I am unaware of that at the moment, but I can come back to the committee with that.

Ms FORREST - In ICU?

Mr BRAKEY - In ICU, yes.

CHAIR - And Ward 4K beds?

Mr BRAKEY - Ward 4K has four beds.

Ms FORREST - That are not being used?

Mr BRAKEY - That are not being used, yes. They have been benchmarked for staffing but those staff have not been advertised and those beds have not been opened. We have already spoken about Ward 4D. We have had a current grievance running there. The beds there have been open to 24; there are 29 beds available.

CHAIR - Sorry, LGH?

Mr BRAKEY - LGH as well. These extra beds have not been staffed and we are seeing the pressures on the emergency department.

Ms FORREST - Is 4D where paediatrics is?

Mr BRAKEY - No, 4K is paediatrics.

The psychiatric emergency nurses promised by the Government - one per day, per shift. It has been advertised. That is not enough to attract a nurse to that position who would be looking at leaving probably full-time rotational shift work, so losing 20 per cent of their wage to take up that position.

Ms FORREST - One day a week did you say?

Mr BRAKEY - No, one per day.

Ms FORREST - So not covering the 24 hours you are saying? It is only eight hours.

Mr BRAKEY - Yes, not enough to attract a nurse and not enough to support the staff.

CHAIR - Can we clarify that? It is for an eight-hour shift?

Mr BRAKEY - Yes, per day. There are 16 hours a day where there is no psychiatric nursing support.

CHAIR - One nurse for eight hours.

Mr BRAKEY - So, not enough to attract a nurse to that position and not enough to support the staff. Obviously, psychiatric admissions are not coming just in that eight-hour period; they are coming 24 hours a day. As you requested during our last hearing, we will be forwarding the

solutions our members have put forward that the Government needs to immediately fund to release the pressure on the LGH emergency. That will be with you by the close of business today. I will hand over to Scott now.

Mr RIGBY - Thank you for the opportunity to come down today. I have been thinking long and hard. Everything has been said. As Andrew has reiterated about the severity of the issues and the fundamental issues, this issue has been a longstanding one for the LGH. I have been in my position now for just a bit over five years, and it has been longer than that where our ED has had issues regarding our length of stay. The biggest issue we have is our length of stay for our inpatient cohort, admitted to the ward. Twice now in the last four years, we have been the worst emergency department in Australia regarding that.

CHAIR - The LGH Emergency Department?

Mr RIGBY - Yes, it has.

One of the things I need to go back to is that it is through no fault of individuals there. They work very, very hard. I am very lucky to have the team I have, getting them in and mucking day in and day out. That is what is quite humbling, I think, in all of this. It is two-faceted issue. We have the staffing and we have also the issues we have at hand. What we are now seeing is where this is coming together. We have had such a great core staff group, and they still are, but you can see the pressure and the strain they are under. Fundamentally, that is becoming just as big an issue as the bed block is.

Ms FORREST - The staff stress?

Mr RIGBY - The staff stress. We have highlighted in our risk register regarding work, health and safety for staff and now putting measures in place to support them through that.

CHAIR - What supports are in place for individual staff on the ground?

Mr RIGBY - There is not enough. Being ED, you are very strong. Very strong personalities work in an ED. We are proud and humble people, and it is sometimes hard for them to reach out for help but more and more we are seeing that. I am having more and more conversations that illustrate they are struggling, let alone reading what is in the press and what is being said by the ANMF. It is very real, and very real to them. They go into that job for a reason. They go into the job to help that person coming through the door and when they are constantly under pressure and constantly cannot get that person in to give them the treatment they need - it weighs heavily on them.

CHAIR - With that circumstance where, say, for instance - and I do not know how often this would happen - someone passes away while they are waiting for attention: what sort of stress is that putting on the individual? Is it something they see so often that it does not have a big impact or do you hear back from nurses who are finding it difficult to cope because of that? Can you give us a bit of an understanding in that regard?

Mr RIGBY - I think because of the ED and its layout, we do not have a spare bed at times to play with. Just to give you an example of our 42 bed department and we have five beds sectioned for a fast track-type area. That is a little isolated to help with the flow-through of people. The rest of the beds are mostly full. We have come onto starting the day with, on average, about 33 to

36 people in the department. We see about 130 a day. When there are people in bed block and they have been in there for a long time, you have less space to be able to deal with that and then it banks up.

When that person becomes acutely unwell, you are scrambling to be able to deliver the best care you can. In the example of that person passing away, thankfully we have not had anyone do that while they have been waiting to be seen by the Emergency Department. We have had people pass away in the ED and that happens often. I do not have the figures, but we are the highest ED for mortality in the state.

Ms FORREST - Are they category 1 patients?

Mr RIGBY - No, there is a combination. The category 1 cohort is seen straightaway and dealt with.

Ms FORREST - Sometimes you cannot save them no matter how good a job you do.

Mr RIGBY - Exactly, and that is part and parcel of the job. You are spread across so many people now and patients and our nursing staff will sometimes look after, between their pair, eight to nine patients. You are scrambling across that. When that person is passing away, whether it be gracefully or you are doing the very best you can, you are scrambling to cover all the bases with that patient and you are looking after those other acute patients. That weighs very heavily and we have had long discussions with the staff about dealing with that. One of our grade 4 nurses is looking into death in the EDs and trying to put things in place for support because we are seeing it more and more.

CHAIR - There is one statement you make in your submission - that the escalation strategy is still only initiated reactively rather than proactively, then you reach crisis point far earlier and adverse events are occurring as a result of that. Do you want to expand on that side please?

Mr RIGBY - Part of that submission is because the escalation plan is in there for a reason and you escalate where you are at. We do that each and every day. There is a plan in place where we escalate it up to the hierarchy. When you are in level 3, 4 - and I received the figure yesterday - 70 per cent of the year so far - you become a little immune to that. I am not saying people are not trying, because they are. They are desperately trying to move people on. There are many good people doing that. When you are at that level the whole time, it makes it very hard.

CHAIR - From your perspective - and we heard a little about this from the others who came in the other day - the triggers that initiate a level 4: what are they and how does such a status impact operations?

Mr RIGBY - At the Launceston General Hospital, we only go to level 3. Within those, the triggers are very similar to Hobart's. I find it very hard to compare Hobart with us; we have completely different issues in that sense.

Ms FORREST - Why is that?

Mr RIGBY - In the sense of our patient demographic, our medical staffing cohort is completely different. We have struggled for a number of years for a full capacity of medical staff.

Ms FORREST - Like physicians?

Mr RIGBY - Physicians, consultants and registrars to complete that. That was evidenced with the accreditation being taken away recently. We have struggled for a number of years with that. Hobart luckily, and I will not speak on behalf of Hobart, has that.

With the escalation in our bed cohort, our capacity in the hospital is completely different. Other avenues are available here in Launceston and other avenues are available in Hobart. Our escalation triggers are very similar in the sense there is a robust patient flow unit in the Launceston General Hospital that tries very hard to come together and they meet up to three or four times a day to discuss avenues.

When you start your day in level 3 escalation, it is very hard to get that back at the moment. Our demand far outweighs our capacity.

Ms FORREST - Thanks, Scott. I empathise with you. It is a while since I have been in those situations but I remember it can be challenging. I want to drill down on a couple of areas. You talked about bed block as an issue and you talked about the lack of physicians and medical support. I understand the hospital relies on locums a lot more than perhaps the Royal Hobart Hospital does, but another problem further up the coast, when you get up there.

Can you talk a bit more about the impact of the lack of the appropriate level of medical support, not just in the DEM but in the medical ward? We've heard from other witnesses that part of the bed block issue is where patients can't get into the medical ward, because people in the medical ward are waiting for something. I would just like you to talk through how you see that and talk about whether you have enough [inaudible] in the DEM as well, or is that an issue as well?

Mr RIGBY - I will just touch base on that [inaudible], yes it is. That is an issue. We don't have the consistency in practice and in the leadership. We have a director that is trying very hard to be able to alleviate that and she is. If you do not have your full cohort of people, it is one person trying to do the job of 10. It makes it very hard and no-one can do that. To build a consistency in practice that we need to flow through for the whole department, it is very hard. When we have a transient workforce that puts extra strain on the rest. It is not just the nursing staff, it is actually the support staff - our clerks our hospital aides and our support officers.

Ms FORREST - And your cleaners.

Mr RIGBY - And the cleaners, absolutely - it flows right through. We are a big family of 200 staff up there, and that is not counting the doctors. That is a big issue for us in the ED itself. It does not take a rocket scientist to figure out why that is such a big issue in that sense. When we talk about bed block, bed block is a whole-of-hospital and whole-of-system issue. Sometimes we focus too much on a hospital-based service delivery when it should be the whole organisation and a health service. That includes primary health as well.

We focus a lot of attention on that, but this is a big picture issue. It is not just about the ED and it is not just about the wards; it is about that whole health service, primary health, rural facilities and our GPs and people like that.

Most of our GPs are doing a fantastic job, but their books are full. They can only see a finite number.

Ms FORREST - Is more of your bed block related to medical patients or surgical patients?

Mr RIGBY - Yes, the medical patient cohort is our biggest issue.

Ms FORREST - Can you see solutions there? I know you don't work in the medical ward, but you are trying to get patients out into it. If you were the minister, is there something you think could be done that could alleviate some of that pressure?

Mr RIGBY - I think the legislation going back to 2008 - and we had varying capacity over that time with beds closed, opened and different things. Ever since 2008 every study done shows our demand outweighs our capacity. It is as simple as that at the end of the day. We can all gain efficiencies. We can gain efficiencies in the ED. We can gain an hour here and an hour there, but every ward can do the same. They are desperately trying with the resources they have. The longer I stay there, the more I get that picture our resources just aren't enough.

Ms FORREST - You made the point about the lack of appropriately trained physicians to assist in the DEM to deal with the medical patients, or even the surgical patients with medical issues who may need to go theatre. I raised with some of the other witnesses, as it was raised with me by a physician, that in America and other places they have what they call a 'hospitalist', which is basically a specialist position that is not a VMO, disappearing off to do their private practice or spend all day in outpatients, but who is responsible for the medical ward. When patients are admitted from the DEM, they are seen by the physician, not just by the junior resident potentially. The patients who are ready for discharge are actively discharged by the physician and the physician also is responsible for the care of medical patients or patients with medical needs in the DEM. Do you think a model like that would help?

Mr RIGBY - The simple answer would be yes. It is just having those resources to be able to do it.

Ms FORREST - Again, do you not have a physician who is really available to even do that sort of role?

Mr RIGBY - I am not fully across what the staffing is on the medical or the surgical side of things. I can only do that anecdotally in the sense of conversations I've had and obviously I've been a part of projects going through. A program like that and the multidisciplinary approach, an efficient multidisciplinary approach, where everyone turns up at the table and plays their part and we see examples of that where they don't. That doesn't happen at the moment. That does cause an issue trying to get a patient out the door. If they all got to the table and everyone played their part - pharmacy, the whole kit and caboodle - it would be a lot more efficient.

Ms FORREST - Would it streamline the patient journey, if you like?

Mr RIGBY - Yes, absolutely. A lot of that comes back to the education of the patient themselves, our engagement of them and telling them what is happening with their stay from the start. A lot gets talked about discharge planning: set the expectation from the start. We don't do that with the patient coming through the door to say, 'This is part of your discharge planning and here is the expectation that your length of stay is going to be a couple of days.'

Ms FORREST - That is a matter that could be implemented or improved?

Mr RIGBY - Absolutely.

CHAIR - With the operational aspects of this, the patient tracking and management system, is that operating efficiently and effectively for you? Do you see any issues?

Mr RIGBY - It could be a lot better. We have multiple systems across the organisations and a couple of years ago brought the EDs together across the state, which are now linked with the system, but that does not link with anyone else.

Ms FORREST - Such as primary health?

Mr RIGBY - That is right. We don't get that engagement from them. Our communication back to them is not good either. The last time we looked it was about 60 per cent - where our communication goes back to the GP after that person presents. There are a lot of systems in place that don't talk each other very well at all, like pathology, radiology, that sort of thing.

CHAIR - Is this within the hospital system?

Mr RIGBY - Yes. So you have to click on the multiple icons to be able to see -

Ms FORREST - Is that because pathology and radiology are privately operated? Do you think that is the barrier?

Mr RIGBY - I'm not sure, to be honest. The engagement is there. Pathology is still with us up in the north and they work within a hospital setting and, funnily enough, they use the same system but they don't talk to each other.

Ms FORREST - That is a matter for the IT department.

CHAIR - That is why I was asking the question.

Ms FORREST - Can I go to another area?

CHAIR - Yes.

Ms FORREST - In your submission, you talk about the serious assaults that have occurred in the ED. Can you talk to us about what you perceive are the causes, let alone the impacts? Is this because of the acuity or the nature of the patients presenting? You also talk about the increased acuity of patients presenting. I would like to understand why you think that is happening. That is absolutely unacceptable by any measure. I am interested in why you think it could be happening and what needs to be done to stop it happening.

Mr RIGBY - The university, in collaboration with us, did a research project on that around two years ago. It started two years ago and they are slowly working their way through that. We are nutting out the causes and the effects, but we are seeing an increasing number of aggressive incidents in the department. Part of that is because we are recording them a lot better as well.

Ms FORREST - When you say recording, do you mean writing them down?

Mr RIGBY - Within our reporting systems. Part of it is that but it is only a small part. We are seeing a large increase in the number of code black and aggressive incidents, and there are varying levels of that. Some are very simple. Sometimes it is about the unhappy person and dealing with that straightaway, and we put a system in place to deal with that very quickly and efficiently.

Ms FORREST - Is it because they arrive unhappy or become unhappy when they are waiting?

Mr RIGBY - Both. They arrive unhappy, with the expectation of being seen very quickly, or they have been waiting for a substantial amount of time. Some people, in their illness, whether it be medically, surgically, mental health-related or substance abuse-related, could be okay for a while and then you don't quite notice that attitude change when you are busy doing a lot of other things. If you don't jump on that straightaway, aggressive incidents can happen. I think a lot of it is substance abuse. We have a huge cohort of that in Tasmania, let alone in the north. The time that submission was taken was around the time we had the concert down in St Helens; whenever we see a big event like that -

Ms FORREST - One Night Stand?

Mr RIGBY - Yes. We see more of an increase in substance abuse coming into the department.

Ms FORREST - That was a drug-free event.

Mr RIGBY - Yes. It is not necessarily related to the event; I will make that clear. It is more about the people and the volume of people who are around. It is varying. We live in an angry society at times, don't we? People's expectations and lack of respect creates issues. What we are seeing now is that age bracket where that happens is slowly getting younger.

Ms FORREST - Where the aggression is on display?

Mr RIGBY - Yes, and that has obviously been well-documented in the media as well.

CHAIR - Are there any particular drugs?

Mr RIGBY - It varies. We just had a spike of ice, but alcohol is still the number one. We have put a few measures in place with our alcohol and drug services up in the north to make it better but they are a finite resource as well. One of the big issues we have right across to everything we have talked about today is that there are many services available Monday to Friday, nine-to-five. I talk about it with the staff group. When you talk about Monday to Friday, nine-to-five, that is only five shifts out of 21 for the week. You've got a huge time frame that is not covered.

Ms FORREST - I remember you speaking on the radio when some of these assaults were occurring and I came on after you a little while back. You also talked about having discharge nurses basically working over the weekend because some services are nine-to-five and it seems that some hospital services operate on a nine-to-five basis. Again, for the record and our

committee, what do you see as some of the solutions to clearing out beds over the weekend, so that when you come in on Monday morning some of DEM patients aren't still there from the weekend? Can you talk us through some of the solutions?

Mr RIGBY - Absolutely. We have to spread those services across the outreach team mentioned here and the medical team that does the review of the weekend to be able to discharge. It is also the allied health component, which is a huge and such a beneficial component. We need to spread them across the whole weekend for those OT and the physiotherapy referrals. We have an aged population, we have the oldest population in Australia, and we need those assessments to be able to happen. That elderly person may be able to go home on the Saturday instead of waiting until the Monday until the OT goes in there and checks them out. I think more resources for nursing and medical and right across the allied health staff as well to be able to have that holistic care because they are such a major player. Sometimes you can even put things in place where allied health does 99 per cent of the work.

CHAIR - I would like to know about ambulance ramping and your impressions of the relationship between emergency department staff and ambulance staff. What is that like? Are they coping or is it pushed?

Mr RIGBY - It is a really tricky one. It is the same thing when under pressure and we only ramp when we are bed blocked, which is more and more now. The ambulance service only has finite resources to serve the general public, and in the north they have fewer resources to spread across. If we have, which we have had a times, up to eight trollies ramped in that area, there is next to no-one servicing the community. They are feeling the pressure to get back out and respond to those calls and they do it very well with the resources they have. It is human nature, isn't it, when you are under so much pressure and you are both fighting for that space or bed? Ambulances are about 33 per cent of our presentations to the ED, so we have to balance that with the waiting ramp but the ambulance staff don't see that in that way. They have their own issues. They don't have to worry about that side of it, which is completely justifiable, but the triage nurse does. We have had a few issues regarding that sort of interaction between the two. Overall, we have a very good, open relationship, and we meet most days to discuss things.

Ms FORREST - You meet with the ambulance staff?

Mr RIGBY - Yes. If it is not me, it is our associate NUMs and their supervisors who will come down most days and we will have a catch up at 8.30 a.m. They have been invited to be part of the hospital conversation regarding bed flow as well, so they are informed. Like anything, the more you inform people, the better off you and that working relationship can be. It is all about communication sometimes.

CHAIR - Do you often see patients being treated in ambulances?

Mr RIGBY -I don't see it in ambulances, but definitely on stretchers and in an environment that is not conducive for that to happen in.

CHAIR - You talk in your submission about intubated and ventilated patients coming in. You might have neurosurgical services being required, an ICU bed. You were talking, in your submission, about one patient waiting from 4 o'clock in the morning until 4.30 in the afternoon, which is a 12-hour wait. Do you want to expand on that and how that might be impacting on the staff and the patient?

Mr RIGBY - I'm not sure if that was in our submission.

CHAIR - I think it was. Sorry.

Mr RIGBY - There have been instances where that has happened.

CHAIR - My mistake.

Mr RIGBY - There has been instances where we have had to wait.

Ms FORREST - They don't do neurosurgery at the LGH.

CHAIR - No, they don't, I realise that now.

Mr RIGBY - There have been instances, obviously, not for that length of stay. But there have been instances where that wait does happen and it does weigh heavily on the staff involved. You want to do the very best for that patient and their family.

When our environment is so heightened, noisy with lots of activity, it is not the best environment for the family to deal with that pressure. That is what the staff see. They can do their job very well. That is why I said at the start that I am very lucky to have the staff I have. They do their job very well, day in, day out, but you can see their anxiety. They want to do their best for that family. When you have such a busy department and being spread across so many different things, it is very hard.

CHAIR - What about the availability of agency staff? Does that ever become an issue in terms of providing resource?

Mr RIGBY - No, we don't use agency staff.

CHAIR - You don't use agency staff at all?

Mr RIGBY - Not in the ED. When we go to staffing, there is a dramatic change in our staff from when I first took over until now. We had such a stable group; a great group of, for want of a better word, oldies, who had been there for a long time. They came to the end of their careers and they left a big hole. We put some processes in place to cover that, but we could not cover that amount of expertise and experience quickly.

The staff we put in place stepped up to the plate really, really well. But what I am seeing now is the availability of staff to come onto the roster is less and less. The availability of people wanting to come on the roster is less and less. Whereas before there were people knocking down my door to come.

CHAIR - We look forward to solutions coming through. It will be very good to look at some of these solutions.

Ms FORREST - I assume that ANMF will prepare a budget submission?

Mr RIGBY - Yes, we will.

Ms FORREST - When do you usually prepare that?

Mr RIGBY - Towards the end of this year.

Ms FORREST - If you would forward it to the committee, unless we have reported by that stage, it would be helpful to provide a lot of good information about how the ANMF sees the challenge.

Mr RIGBY - I could probably forward you our previous budget submission. These issues have been going on for a long time. I think many of them will be covered in our previous budget submission.

Ms FORREST - Okay, that would be great.

CHAIR - Is there anything else you wish to bring out at all, Scott?

Mr RIGBY - Just the fact that what we talked about is very real. The experiences that have been in the media, as well as what the staff have talked about and what you have heard before, are very real. They are not just things that are made up.

I understand people are working very hard to make changes, but those changes have been promised for a long time. I have been witness to that sitting in my job. Unfortunately, words are just words. We really need the actions to take place in that. That is not to belittle anyone, but that is the problem. We are dealing with people here. It is very real for them. I think we owe it to them to start delivering on that.

CHAIR - Mention is made of the privacy issues of treating patients coming through the emergency department. Do you want to expand on that a little?

Mr RIGBY - That is where I talk about an area we have. Because we are so full, we are blocked, our cubicles are all used and we have had to convert our security room into an assessment room, so we can take somebody in to assess them quietly. That room is more being utilised more and more. We are treating people in the waiting room and when someone is sitting in a seat with someone behind them; it is not private or confidential. Obviously, you do not have conversations that are not appropriate, but it is still not good for that patient to be sitting there while you are taking blood or doing something like that.

The triage-assist area is where we have our ramping area and where we have our quick assessment area for the triage nurse. That is predominantly full. At times we have had eight ambulance trollies and three other people sitting there, so 11 people in a space just a bit bigger than this table. As you can imagine, there is no privacy.

CHAIR - A question about mental health patients. Do you have concerns and issues about mental health patients presenting at the emergency department and how they are dealt with?

Mr RIGBY - Yes, we do. We do not have Hobart's length of stay. At times it has been up to two or three days, but not the amount of that either. We have issues regarding their process of care, depending on how they present and who gets involved. That can start with the ED. The ED

sometimes has an issue in dealing with them through that person very quickly and efficiently. More than likely it is down to the medical staff you have on that shift.

Ms FORREST - You do not have psychiatrists readily available?

Mr RIGBY - No. They go through a process and it is disjointed process, unfortunately. They people who are in it try really hard. They do a great job when that person comes in, and they will probably have to speak to three people before the decision is made for admission. When you are in an acute mental health state, that is the last thing you need. They talk to the ED and they talk to the ED staff and then they go through a crisis assessment team, then they go to the psychiatric registrar or then even to the psychiatric consultant. They see up to four people and that takes time, depending on their availability.

Psychiatric staffing is just as bad as ours in the ED. Those people are limited. The registrar could be on call overnight and then they must have their fatigue break so we do not see that person until 1 o'clock or 2 o'clock in the afternoon. That person could be sitting there all day.

CHAIR - Do you have mothers and babies coming in, presenting with mental health issues and needing to be dealt with?

Mr RIGBY - Yes, every ED does. That has never been an issue for us in that sense.

CHAIR - It has been able to be dealt with appropriately?

Mr RIGBY - Yes, absolutely. We are working with DOCs [inaudible] with mental health, and also women and children, regarding baby welfare.

CHAIR - Nurse practitioners have something that has come up in our inquiry. Do you feel there is a place for more of them in the system?

Mr RIGBY - There definitely is, particularly with our ED because of our longstanding medical issues. There is definitely a place for our nurse practitioners. We have three there at the moment and they work very hard. They are major players in keeping our lower categories, the category 5s, flowing through the department. We service our category 5 patients very well.

CHAIR - For the record, what is a category 5?

Mr RIGBY - Category 5 is a person who is deemed at triage who can be seen within two hours. It is for lesser complaints - simple fractures, simple stitching -

Ms FORREST - Vomiting and things like that?

Mr RIGBY - That is right, early pregnancy issues and lots of different stuff. They can see any patient but they predominantly stay in the categories 4 and5 because that tends to be your lower acuity and quick assessment. Theoretically, your 15-minute assessment and be dealt within half an hour.

Ms FORREST - Either you are out the door or wherever?

Mr RIGBY - That is right - get radiology, pathology and those things.

CHAIR - Did you say you need more of them?

Mr RIGBY - We could always do with more, absolutely. There would be a model. The ED is now broken down in different areas. We call it fast track; I am not sure why.

Ms FORREST - It is an aspiration.

Mr RIGBY - That is right. Our nurse practitioners predominantly staff that. That helps with our flowthrough. If we could staff that 24/7, we would be laughing.

Ms FORREST - I know when nurse practitioners were first being considered and then the course was developed, there was a bit of pushback from the medical profession for the obvious reasons of turf wars. Do you see that changing?

Mr RIGBY - We have an issue with our clinical support, and that has to come from the medical staffing. It cannot come from any one of us in the nursing crew. We have an issue with our ongoing clinical support. They have been embraced by the ED staff. I will not necessarily say they have been embraced by the rest of the medical cohort because we have had issues. We have had issues with our Radiology Department regarding embracing them.

Ms FORREST - Accepting their referrals?

Mr RIGBY - That is right. That is slowly getting better, the more and more time goes on, but we still have an issue in the north of our clinical support for those nurse pracs.

CHAIR - I think our time is pretty well up. Is there anything else you wish to bring to our attention, either of you?

Mr BRAKEY - I will just make a quick closing remark. It sounds like many witnesses have raised a lot of very good ideas as far as creating efficiencies within the system. I think when we look specifically at the LGH, you heard from Scott today about the pressures currently in the Emergency Department and the fact there are more beds at the LGH that could be opened to release those pressures. As much as we should be looking for efficiencies within the system - ANMF completely agrees that - what we should be looking at is releasing that pressure now and then looking at the efficiencies and deciding what the bed numbers need to be like down the road. It is not safe and not appropriate that the Emergency Department at the LGH is under the pressure it is now when there are those solutions, which you will get in our submission at this time.

CHAIR - Thanks for that. Once again, just remember that what you have said here today has parliamentary privilege, but it may not if you walk out there door and talk to the media. We really appreciate you taking the time to be here. It is difficult enough to deal with the pressures and things in your own work, let alone taking time out to come and talk to us, but that is really appreciated.

Ms FORREST - Please d acknowledge and thank the staff on behalf of all of us for the work they are doing.

CHAIR - They would be covering probably.

Ms FORREST - Someone is doing your job while you are not there.

Mr RIGBY - No worries. Thank you.

THE WITNESSES WITHDREW.