PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY 14 SEPTEMBER 2018

ACUTE HEALTH SERVICES IN TASMANIA

Associate Professor ROBYN WALLACE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - Welcome to the inquiry. We are taking sworn evidence today; this committee is being recorded on *Hansard* and streamed live. All evidence taken today is protected by parliamentary privilege and I remind you any comments you make during this hearing, if mentioned outside the hearing, may not be afforded such parliamentary privilege. You have a copy of the information for witnesses, which is in front of you. Have you had an opportunity to read that and are you aware of that process?

Assoc. Prof. WALLACE - Yes.

CHAIR - The procedure we intend to follow today is that first you will be provided an opportunity to make an opening submission. Following that, each committee member will have an opportunity to question you on any aspect of your submission within the terms of reference we have for the inquiry. We are seeking information on acute health services in our major public hospitals around the state. If you feel there is something you wish to say that needs to be in camera, you can request we do so and the committee will consider that request.

Assoc. Prof. WALLACE - Ruth, Rob and Kerry, I am immensely grateful to be given this opportunity to speak to you about acute health services in Tasmania, particularly in the hospitals. I am talking about groups of patients who are well known to be high users of the hospital system. That is, people with mental illness and people with intellectual disability. I am a specialist physician and work with patients in the acute hospital setting and outpatients in the private sector in Tasmania. I also teach and research, and am involved in many groups outside the healthcare interest groups.

It is not unique to Tasmania; it is well known in Australia and all over the world that people with disabilities are very vulnerable in the health system. They are high users, and they endure higher rates of preventable morbidity and mortality in the hospital setting. They are readmitted more often. They receive a lower quality of health care. It costs more and it is less effective. The good news is that it is treatable and we do not have to reinvent the wheel - a lot of work is being done that we can use to improve this.

It is a particular problem in Tasmania because we have the highest rate of disability in Australia. It is not going to improve, it is not expected to decline and we know the gap between physical health outcomes of people with disability and those without is increasing. It is not decreasing.

Ms FORREST - Are you talking about all disability, not only mental health disability?

Assoc. Prof. WALLACE - Mental health and intellectual disability; the gap is increasing.

Ms FORREST - This is for that sector of people with disability?

Assoc. Prof. WALLACE - Yes. This disparity in acute health outcomes has been recognised and there are recognised guidelines - 'Keeping Body and Mind Together', written by the Royal Australian and New Zealand College of Psychiatrists, while the Mental Health Commission has written 'Physical health and mental wellbeing: an evidence guide'. The National Mental Health Commission written a document called 'Equally Well'. I commented on a draft of an Australian Commission on Safety and Quality in Health Care document, the 'National Safety and Quality Health Service Standards user guide for health services providing care for people with mental health issues'. We have many guidelines in place already. Here is another article recognised in *The Lancet*, 'No health without mental health', which describes the mental and physical health issues.

I have looked at the otherwise excellent Rethink Mental Health program of our own government. It does not mention physical health, unfortunately. It is a great guide for acute mental health services, but it is a major deficit, said respectfully, that it doesn't mention physical health. People with mental illness are high users of the physical health hospital. If you have mental illness you are more likely to seek care in a physical health hospital. If you have a physical health problem with mental health, you are more likely to go into mental health services. It works both ways.

The other gap in our Tasmanian services for people with mental health and intellectual disability is in transition. While we have excellent paediatric services for children with developmental disabilities and children with mental health problems, when they go into adulthood there is no good transitional level of care or program. Having said that, Primary Health Care has taken on an initiative to develop a transitional framework for all sorts of physical health problems from paediatrics to adults; that is being launched later this year.

What do we do about it? The first thing is to acknowledge the problem, take it on board and increase our awareness of this disparity in health outcomes and the preventable nature of it. The second issue is to have in our minds that we want to make the health care of people with mental illness and intellectual disability part of our normal service. We want to make it the norm. To start off, we might have to make a big special effort to kick in a program with supports and design the reasonable adjustments, which are in the literature, to implement all the tips in these documents; fantastic, implementable tips.

Another important part of our thinking is to do more with what we have. We cannot use the barrier of saying we do not have any money. We have to embrace this and work more with the resources we have, and I think we can. We can improve what we are doing with our current resources and that is vital. Some of the ideas are for implementation of a statewide service, also straddling public and private, where possible. I mentioned in my submission smallish numbers of people with certain conditions. These are minority groups but they are important minority groups. Clinicians need a certain number of patients to increase their skills. In either the private or public, you may not have enough patients, so it makes sense to combine your resources - straddling both. In a small place like Tasmania, potentially combining services would be an asset for us.

Ms FORREST - You are talking public and private?

Assoc. Prof. WALLACE - Yes, somehow. Outpatient services are important to try and prevent inpatient admissions, to follow up people who have been an early outpatient. We know, for example, that people with heart failure, mental illness or intellectual disability are more likely to be readmitted. In the case of heart failure, early follow-up as an outpatient prevents readmissions and that is what we want to do. We want to prevent admissions and readmissions to the hospital. Within the sort of department in medicine would be internal medicine. I am an internal medicine physician. Our brief is to cover the health care of people with lots of medical problems and complicated lives. That is our bread and butter as a general physician. It does not mean we do not use the cardiologist or the neurologist, but our brief is the baseline for complicated patients. GPs refer patients to us with lots of medical problems and we sort them out - inpatients and outpatients - a dedicated outpatient system within internal medicine for adults with intellectual disability for patients with mental illness.

Within that service there are particular health problems. Smoking is very high for people with mental illness and while not the entire cause of all of their health problems, we can help support primary health care to implement the smoking cessation measures. It might be instead of the nicotine going four weeks at one level then three steps of nicotine replacement therapy to stop smoking, we adjust it so the nicotine patch cessation period is longer. Instead of having three goes and failing, a patient with mental illness might need 10 goes before they stop. It is worth it and we understand we give people with mental illness more chances. We have to be ready to give them more chances because we are here for our patients - it is not the other way around.

In particular, this draft document has some very good tips for standards and principals of how to manage inpatient care. It applies to physical health and mental health inpatient wards, a standard we have to meet anyway, but it is a particularly helpful, practical guide. For patients with mental illness, we already have in public hospitals a psychiatric liaison service, for example, where if I have a patient in my inpatient ward, I can call psychiatric services if I need them. I do not think this is enough. We need a more proactive linking between psychiatrists and physicians. In the psychiatric ward, we need a proactive approach for physicians to go into the mental health ward and there are barriers. For example, in the wards in internal medicine, people are in pyjamas, in beds and you know they are sick in hospital.

In the mental health wards we have to have a swipe card to get in. It seems stark. People are not in their pyjamas. Now they might seem little things to you, but they are all barriers for the physician going into the mental health ward. There are all sorts of things that make it feel different, such as the patient might not be in their bed. We need make it the norm that you go to the psychiatric ward and proactively look at the physical health. How many patients have I had or seen where an acutely unwell patient with mental illness or with a chronic health problem and the physician says, 'Oh, it is psychosomatic, schizophrenia or depression', when in fact they have a serious physical health issue. It is the same with intellectual disability.

I have presented here before. In Tasmania I have a pile of files this high of patients who have died this year in our hospitals - preventable deaths, I believe.

Ms FORREST - Of patients with mental health issues or intellectual disabilities?

Assoc. Prof. WALLACE - This is intellectual disability. They are two separate groups but they have similar problems. We need a dedicated medical presence in mental health wards. We need a dedicated psychiatric presence in medical wards. We need dedicated outpatient services to address the physical health of people with mental illness and the physical health of people with

intellectual disability, transitioning from children just coming in fresh. Although that is a bit of extra money, I think that one day in hospital is about $5000 when you add everything up while an outpatient might be $400 for the costs of the infrastructure and so on. It is a lot cheaper and a lot better for the patients.

We also need to keep track of our data of adverse events, deaths and preventable medical events in this population. At the moment we are one of the few states where we do not have a register of deaths of people with intellectual disabilities. In clinical review committees, often the deaths and adverse events pass through because of thinking that is what happens to people with disability, but it is not. They do not die and they do not have to die at the age of 40 or 50, or even 60. It should be the 80s or something like that, as the general population.

It is about getting the coroners reaching out there - perhaps reminding them of having a report each year particularly on this group, of what is the year's report of the physical health outcomes of people with mental illness in medical wards, what happened to our patients with intellectual disability in our wards this year and reviewing that, learning from it and improving from it - not scapegoating but learning from it.

Changing the subject now to Commonwealth funding arrangements and its adequacy, point 3, this is relevant to the National Disability Insurance Scheme. It is potentially solvable and it needs to be sorted out. The way things are at the moment, if an individual with intellectual disability living in a group home goes to hospital with a seizure or something, the funding of their disability support is a grey area even when they have NDIS. It needs to be clarified: who funds their disability support? The NDIS has said in one of the COAG documents that they would fund inpatients for the disability support if they had complex communication needs. Most patients I know with intellectual disability do not all have complex needs; it is the nature of intellectual disabilities and the complexity of medical stuff. You need to be able to give a history.

I have followed up with the agency, NDIS, about what they would support. They would fund the support worker to be with someone to be admitted and to be discharged, for maybe one hour a day. But many people with intellectual disability require 24-hour support or 12 hours a day, a lot more. I am proposing that it be clarified that there is a memorandum of understanding between the hospitals and some service providers so that support workers come in, they invoice the hospital, the hospital pays the disability service back and then the hospital gets that money from the from the Commonwealth body.

Ms FORREST - Are you talking about the NDIS as a Commonwealth body?

Assoc. Prof. WALLACE - No, there is a national health funding body, which is a Commonwealth body that funds hospitals for complicated patients, if you have refugees and Indigenous people. They could potentially fund the hospital on cases that need more money.

Mr VALENTINE - They review the operations of hospitals at various times?

Assoc. Prof. WALLACE - They provide a bit more depending on the complexity of the case mix. Prior to NDIS, our hospital had an arrangement with some service providers - willy-nilly which ones - that whatever disability supports were needed, Royal Hobart or Aurora or Mosaic would fund Aurora or Mosaic would fund the service provider for the supports and then Royal Hobart would apply to the National Health Reform Body and be reimbursed.

Ms FORREST - Is that working?

Assoc. Prof. WALLACE - It is still fuzzy, but as far as I am aware the National Health Reform Body is still able to do this. Not all health disability service providers know about this system. The National Disability Service should be able to tell all the members. I do not know if it is. I am talking to them about it, but NDIS will also cover some of the funding. It is messy, but as a logistical arrangement it can be sorted, but it needs to be clarified so all disability service providers know about this.

At the moment, the service provider policy is a patient goes in with their folders and no-one with them, so a patient who cannot speak cannot point to pain. The doctor is not a magician; they need to know what has happened.

CHAIR - They probably have not the time to trawl right through all the details?

Assoc. Prof WALLACE - No, well, they do not do that. One of the necessary reasonable adjustments is they might have to take more time. The great gap at the moment is you absolutely need the disability support worker there with them. Not a hospital sitter - you need someone who knows them.

The National Health Reform Body does not apply in the private sector - for example, there is the Mary Potter Foundation at Calvary for patients who have intellectual disabilities and need hospitalisation. There are not many and they can potentially have their supports funded partially by the Mary Potter Foundation. The service provider might also use their own kitty to help provide the required disability supports.

In summary, every person with intellectual disability would have a prepared disability supports plan for what they would need when they are in hospital. It might be more than usual. When they are in hospital, the plan would indicate they need this many hours of support per day.

The funding of it would be sorted out with some from the hospital, the National Health Reform Body and/or the NDIS. The service provider and the hospital responsible for the healthcare delivery, would both know. It has nothing to do with NDIS who is responsible for the healthcare plan. When the patient with intellectual disability comes in, the supports are there, the hospital knows they are going to be there and have a bed or a chair ready with occupational health and safety issues sorted out. The person with intellectual disability has the supports to enable them to participate in the healthcare process.

Ms FORREST - Whose responsibility would are you suggesting that is?

CHAIR - Yes, I am keen to get to the end of Robyn's opening remarks so we can then go to questions.

Assoc. Prof. WALLACE - People with mental illness may not have as many needs, but in the documents one of the reasonable adjustments is that there is an expectation someone, a family member or a worker, will come in with them to help with the history on physical health issues. At the moment that is not welcomed in the adult system. There is no room for open-mindedness that people who are vulnerable need support people with them. That problem can be solved. The agency has given a response funding people with intellectual disability.

I have talked briefly about the level of engagement. There is a lot of positive scope there. The same doctors usually work in both. They are fantastic doctors and I am not criticising the quality of our healthcare providers. There is nothing wrong with Tasmanian's health providers. There are as good as anywhere, but our structures and mindsets sometimes can be improved.

I have also outlined some of those factors in point 5. I am jumping back a bit, looking at the contributors to adverse patient outcomes. They are poor communication and not listening to carers; support staff not being present; support staff doing their own thing; attributing physical health problems to the disability instead of recognising it as pathology; not enough time; and poor attitudes. These are marginalised people who are disempowered. They are quiet in the community. We have to open the door and listen to them. We need to have a consumer involvement in improving their health care access with us.

Recognising that it is a bit more difficult when someone has mental illness or intellectual disability; it is a bit more difficult to do our thing but so be it. We have to embrace that and adapt ourselves because we are the service providers not the masters, so to speak. We have talked about the clinical review committee, the overseeing and looking at events that happen that should not. We suggest getting the health and disability sectors in our own government engaging better together. I think they could even have a sort of a wall between them but they don't talk much.

In summary, we want to make looking after vulnerable people in the hospitals the norm, as part of our bread and butter service. We know they are vulnerable; we know they cost a lot; we know their health outcomes are not as good. We want to fix that. We want to use the current literature on reasonable adjustments to make practical changes. We want to implement the safety and quality standards at the hospital level of care.

We were acknowledging the seriousness of this disparity and the gap with deaths - earlier deaths, preventable deaths - and preventable illnesses. We want to make a specific effort to implement a lifting of our services but eventually we want to make it the norm. It might require a bit more initial effort and a bit more funding, but it is really a mindset of doing more with what we have. We also have the measurements, keeping an eye on the review and quality of our implementation of new services.

CHAIR - Thank you for that. These have been very comprehensive opening remarks and it is very good to receive them.

Ms FORREST - I hear what you are saying and appreciate it is a really difficult area. It takes me back to when AIDS became a real issue. AIDS patients were getting Kaposi sarcoma and were being put into an AIDS ward but their mental health was the issue. There was this whole disconnect between physical and mental health. This seems a bit similar.

You talked about the need to develop a mental health plan. That is a really important aspect of it. Could you talk us through that a bit further? Would the person with the disability or the illness do that with their support worker ahead of time? Who is responsible for that? It is the same with an advance care directive - it would be ideal but not everyone has one.

Assoc. Prof. WALLACE - Yes, I know what you mean. I am Chair of what we have called the Tasmanian NDIS Disability Health Advisory Group. It does not have any formal authority but its composition included the head of our agency, NDIA, here. The boss of National Disability

Services, several service provider heads, some nurses in disability, someone from advocacy, myself and family members of people with intellectual disability.

We have worked out how we can do this. In the NDIS planning stage you have an opportunity to make this disability support plan for hospitalisation for people with intellectual disability, should it be required. You have different topics. You might have your plan for residential support, your plan for what you are going to do during the day, your plan for support and employment or your plan for health and wellbeing.

Ms FORREST - Does this include admission to hospital or is that a separate thing?

Assoc. Prof. WALLACE - That is what we are saying. We were advocating that it be included in that section. It may or may not be funded by NDIS. In that planning stage you plan all sorts of things, whether they are funded by NDIS or not. That is an ideal opportunity to make that hospital plan. I also provide an outpatient service for adults with intellectual disability at Calvary and that is part of my role. We deal with the acute health issues but I also assist in developing the logistics of - I have paperwork on it and so on - what supports we need in hospital. Western Australia has a beautiful document on disability health interface for people with intellectual disability - who does what job. When the support worker comes in, for example, they do not have to give the drugs or the blood pressure, but they do have to help fill in the menu. They have to talk to the doctors and help with communication. They have to provide emotional support for the patient with intellectual disability. They have to provide information to the nursing staff about toileting and nutrition and swallowing and all that sort of thing.

The nurses are the ones who do the drugs and the observations and so on. People have to know what their jobs are; all that is sorted out, in a way. New South Wales has a sort of plan as well but it is a beautiful document from WA that describes -

Ms FORREST - How long has the WA plan been in place?

Assoc. Prof. WALLACE - At least a couple of years, but there are various ways it can be done. There are a few other models. The point is we do not have to start again. We can just get someone and ask, what is the best way of doing this and do a small project -

Ms FORREST - It deals with issues of confidentiality, the person's confidentiality and of other patients, because they are often in shared accommodation, aren't they? Ideally, they are probably not but sometimes they would be.

CHAIR - Certainly here they are, aren't they?

Assoc. Prof. WALLACE - In group homes?

Ms FORREST - No, when they are in the acute setting in hospital. In terms of when the support worker -

CHAIR - Sorry, I was on Robyn's wavelength with the group homes in the community, but you are talking about -

Ms FORREST - I am talking about when they are in the acute setting. Their plan includes the presence of their support worker on more than simply on a mission to discharge, which would

be needed for a lot of these patients. The confidentiality issue for the patient is other patients in the room, if they are in a shared ward.

Assoc. Prof. WALLACE - That is the same with anyone at the moment. You do a ward round, you pull a curtain across and the neighbour next door often replies.

Ms FORREST - Yes, but the person with intellectual disability may not remember what was said by the patient next door but the support worker certainly might.

Assoc. Prof. WALLACE - That is right.

Ms FORREST - Is that managed in some of these other documents? That is one of the things that can be a bit of a barrier to some people.

Assoc. Prof. WALLACE - Exactly, but you have parents stay in the paediatric hospitals and no-one blinks an eyelid.

Ms FORREST - That is right.

Assoc. Prof. WALLACE - This is one of the reasonable adjustments. We might have to, where possible, have a single room because it could bring on behavioural issues, such as anxiety, and the carer's job is to partly manage that. You will not get a nurse looking after someone one-on-one for behaviour issues for 24 hours. You will for health issues, but not for behavioural issues. You can imagine yourselves, people without disability, going to hospital on your own. You are weakened, you are down, you are miserable and you are frightened.

CHAIR - It can feel quite daunting sometimes.

Assoc. Prof. WALLACE - Absolutely. That is part of the reasonable adjustments - the occupational health and safety issues, meals for carers and so on, and they have a roster and a system of handover. I try to let the disability sector do their thing as much as possible, but together. I do not try to dictate to them what they need. On the other hand, I say, we need to get a history, we need to examine the patient, we need to do tests and we need to make diagnosis and make plans with management. That is what we need when someone is sick. How can you help?

CHAIR - That goes past the present attendants to the event in hospital?

Assoc. Prof. WALLACE - Yes. The carers have to be there for the discharge when the patient goes home, and give feedback to the doctors to say they are not nursing staff. The doctors might not know they are not medically trained and the health literacy of support workers is sometimes low-ish. The discharge plan -

Ms FORREST - What about consent? How is that managed?

Assoc. Prof. WALLACE - If the person can consent, yes, but a paid carer can't provide consent. It is their responsible person or their appointed guardian.

Ms FORREST - So you could have another person who needs to be involved?

CHAIR - A guardian, yes.

Assoc. Prof. WALLACE - Not for day-to-day care. You communicate with them but the person responsible doesn't have to provide consent for baseline medical care.

Ms FORREST - No, but they would for surgical intervention or something like that?

Assoc. Prof. WALLACE - That is right.

CHAIR - Would that be an enduring guardian?

Assoc. Prof. WALLACE - Many people with intellectual disability cannot appoint guardians or enduring guardians. They never have the capacity to do that. A person responsible is the standard, and would usually be a family member. If it is an older person who does not have a family member, they would have a guardian appointed by the Guardianship Board.

In my documents for preparation for hospital I give to my patients with an intellectual disability, I have who is who and the contacts on the front page, including the person responsible or the guardian. I have a photo of the person when they are well. On the second page, a bit like with aged care, I circle the box of skills, of vision, hearing and mobility.

Ms FORREST - Of the patient?

Assoc. Prof. WALLACE - Yes, so the nursing staff can see what they can do and know a little bit about the person. That is not enough - you need the support worker or the family member there. Doctors might have to make appointments. For example, you often can't spend a lot of time having a discussion on a ward round. You might have 30 patients to see but you say you will come back at 2 o'clock and have a proper talk about the planning and clarification.

CHAIR - Can you paint a picture for us as to your interaction with the public system? Are you totally private?

Assoc. Prof. WALLACE - I have tried many times and put many programs and business cases to our state Government for a statewide service for our healthcare products with intellectual disability. As an individual, I was Chair of the Tasmanian State Committee of the Royal Australasian College of Physicians, and through our advisory group, indirectly. I haven't got anywhere with the public system but there are talks, grant rounds, and I attended a conference last week on mental health and physical health. I have good rapport with the public physicians. I do not work at the Royal Hobart Hospital but if patients need imaging or an MRI and they wouldn't be able to have it without sedation, that can't be done in the private system. I have a system whereby that can be done in the public system. I write to the appropriate person, they organise the anaesthetic review and I send them all the notes. That is good. I have great relationships with certain subspecialists at, say, neurology, Dean Jones.

CHAIR - You are well aware of how the public system works?

Assoc. Prof. WALLACE - Yes.

CHAIR - As to services offered through our public hospitals, can you recommend who they should be benchmarking with to get that standard across the board? You have talked about Western Australia but is there a standard?

Assoc. Prof. WALLACE - No, this is new in the world. The service I run at Calvary is very unusual and it shouldn't be unusual - it should be the norm. It is well established in the paediatrics, nothing in the adults. When a person turns 18, their disability and their medical problems don't go away but there is no couch in the adult world. The Department of Internal Medicine is the ideal place. It is a learning process. Even our college of physicians doesn't have a lot of teaching in this area. GPs have the syllabus now, which includes developmental disability but it is mainly paediatric in practice.

It has to be taken on board, even starting as one outpatient clinic a week for people with intellectual disability. I imagine there would be at least one person with intellectual disability in the hospital in any of the wards most of the time. Maybe you would do a rotating consultation around the hospital.

CHAIR - It is breaking down the silos that exist with the hospital to get a better patient outcome.

Assoc. Prof. WALLACE - The last thing we want is a new silo; you are right. We want to make it a little bit separate with, say, a clinic, because the appointments are longer and there are more people that need more chairs -

CHAIR - It is not a complete redesign you are talking about? You are just talking about using the services that you have in a better way, to adapt any services that are there, to get a get a better patient outcome?

Assoc. Prof. WALLACE - Yes.

CHAIR - Thanks very much for that.

Ms FORREST - On point 5 you are talking about some of the reasons things do not go so well. The causes include poor communication, not listening to carers. These are the same things that create a whole lot of problems with people without an intellectual disability. The majority of complaints I get through my office relate to poor communication. It is not like we need to reinvent the wheel here; we need to just adapt it to meet the needs because it becomes part of the normal process.

Assoc. Prof. WALLACE - That is right, and I would say that the clinicians will improve when they deal with people with intellectual disability or people with mental illness; they will improve their skills for people with that disability, I am sure.

Mr FINCH - Robyn, I think the understatement of the morning is 'complex'. That word is resonating as I listen to what you are telling us about the circumstances as you view them. From all that you have said, I am trying to get my head around it and I am coming out the other side with a little better understanding of the issues confronting the people of whom you speak. You might clarify this for me: the way you are talking about the integration and making it normal in the hospital circumstance, first I see the extra requirement of skills for the staff who are there to balance both sides. You talk about lower quality of health care; it might be because of a lack of understanding of how to deal with the issue. Explain to me why, or why not, you would have a separate operation for people who have intellectual disabilities or mental illness. You touched on that outpatient situation. Can it be bigger than that, or should it not be?

Assoc. Prof. WALLACE - Most disability literature now, including the NDIS, is based on this fundamental principle of access to mainstream service - that is the important thing for people with disabilities, a marginalised group. It is access to the mainstream that you and I get, as opposed to making it a separate one-stop shop. Even in education, so-called special schools have gone out a bit - now, it is rather about integration into the mainstream schools. It is the same with health in that there is a global disability view, including in the United Nations et cetera that we make our mainstream services accessible to people with disabilities. That is where we make reasonable adjustments to the mainstream to make it easier and to lower those barriers for people with disabilities to access the mainstream health care.

If we have a brand new empire of health care for vulnerable people, say, we could put people with mental illness, people with intellectual disability, refugees -

Mr FINCH - That is three silos, yes.

Assoc. Prof. WALLACE - In one way it is easier, but if you don't have that specialised service, they cannot get care.

Ms FORREST - It wouldn't be efficient.

Assoc. Prof. WALLACE - You would need another MRI scanner, you would need another set of doctors, another set of infrastructure, and it is against all the principles these days. It is about making the world a better place but it is a mainstream world. One of the NDIS's fundamental principles is having the disability supports for people with disabilities to access the mainstream health care, to access mainstream education, to access mainstream employment, if possible, with the supports in place. It is not denying the disability; you have to make special arrangements and provide disability support, but the hospital has to give a bit and the disability support has to be there.

Mr FINCH - A basic question about a person with a mental illness or somebody with an intellectual disability coming to a hospital, with a carer or without: when they walk through the door, is that a major confrontation for them? Do they find it hugely discombobulating to walk through the door and not feel comfortable?

Assoc. Prof. WALLACE - Yes, it certainly can be. It is well documented that other behaviours and baseline demeanour can change when coming into a hospital because there is noise, there are lots of people, there is waiting, there is sickness, the carers also are agitated that they might be sitting in a chair. This is experienced by everyone as well when they come to the ED, but it is harder for people with intellectual disability. They cannot rationalise the feelings and understand what is going on there and they are out of their comfort zone - there are things they cannot control. Carers cannot remove them to a more comfortable setting.

Mr FINCH - As I mentioned before, there is the requirement by the staff there - nurses, physicians, the person checking them in, all those people - are you suggesting there needs to be a greater awareness by them of that circumstance?

Assoc. Prof. WALLACE - Yes.

Mr FINCH - Is it not part of their training?

Assoc. Prof. WALLACE - There is a lack of training in this area at all levels - medical school, specialty training and GP training. UTAS does have some training on intellectual disability, approximately five hours a year, which is not too bad. The GP and rehab colleges have good syllabuses. The college of physicians, in the adult sector, lacks a bit of input into that and others are agitating for the college to have more content on intellectual disability and mental illness. It is part of the global marginalisation of these people and we have to improve our attitudes.

For example, one strategy might be having people with intellectual disability as volunteers in the hospital; just seeing people with intellectual disability as part of day-to-day business lowers that fear. Even intelligent, fantastic doctors fall away with intellectual disability because they have never been exposed to people with intellectual disability.

CHAIR - They are not quite sure how to interact with them.

Assoc. Prof. WALLACE - Yes, that is right.

Ms FORREST - Cleaning staff and kiosk staff are jobs they can do and do well.

Assoc. Prof. WALLACE - Yes, Calvary uses Blue Line Laundry, which is a disability support service and therefore you do see people with intellectual disability in the wards.

Mr FINCH - They are also at the LGH. I was interested in the Western Australian model and you talked about the way of doing things there. Would you say they are an exemplar?

Assoc. Prof. WALLACE - It a fantastic model.

Mr FINCH - What could we take on from what they do there that might -

Assoc. Prof. WALLACE - I can send you the document. I think we should look at it and make any refinements for our Tasmanian situation. It is a very in-depth document; it is very good.

Ms FORREST - Can it be summarised into two A4 pages? That is what they need in the clinical setting. It probably can be.

Assoc. Prof. WALLACE - It probably can be.

Ms FORREST - I am sure it is very basic when it gets down to it, in terms of the principles. We should get a copy and look at that.

Assoc. Prof. WALLACE - I can send you a copy if you like.

CHAIR - There is great thinking that has gone into this, and sensible. How do you think it would be received by those working in the public hospital system? Is it likely to be embraced?

Assoc. Prof. WALLACE - It is difficult.

CHAIR - It is a difficult question, but you might know from your own colleagues' reaction to what you have been suggesting there.

Assoc. Prof. WALLACE - It is like a vicious circle. It is hard at the moment in non-adjusted systems to manage the health care of adults with intellectual disability in hospital, where you do not have any scope to work. You might have a new patient for 45 minutes. It takes me two, one-hour appointments in outpatients to properly see a patient with intellectual disability. You cannot do a proper job in a 45-minute slot with your beeper sounding, so people develop a 'this is too hard' approach. Arrange a longer appointment and possibly more chairs in my room because there are going to be support workers and maybe family coming.

CHAIR - The patient needs to feel comfortable with you?

Assoc. Prof. WALLACE - Yes. They take a bit of time to walk in and to establish communication and rapport.

Ms FORREST - Sort where they are going to sit.

Assoc. Prof. WALLACE - Yes, exactly. If you want to do an examination, getting onto the couch takes longer. Kerry, you have talked about separation: there are a few different things to be done, but it is still in where general medical has their outpatients. It might be a separate day for people with intellectual disability, where appointments are longer and you stick to the time so there is less waiting. It is the same processes as for people without intellectual disability. There is a bit of specialisation or reasonable adjustments, but still within the generic services.

CHAIR - It saves revisits. That must be quite a significant issue for people with an intellectual disability having to come back for certain services because certain things were not ready at the right time.

Assoc. Prof. WALLACE - Outpatients may be more intensive, but cheaper than inpatients.

Ms FORREST - If you spend the time, it is probably money well spent.

Assoc. Prof. WALLACE - Exactly and the nature of a disability is it does cost more and take longer. That is the nature of disability and if you become more experienced, both of those probably reduce. I am not saying we are going to have the same costs as people without disability. I do not think we will, but we can have lower costs, by being more efficient. More importantly, we will have better health outcomes for people with intellectual disability and physical health problems and people with mental illness.

Ms FORREST - I am sure it is more practical when you are doing it online, apart from the WA thing, the chart steps it out. When I read through this in the submission, I thought it is cumbersome, because I did not understand how it was supposed to work. But it really is a step-by-step for people who are supporting people with disabilities.

Assoc. Prof. WALLACE - And it is brand new. In time to come you would not even bother to look at that.

Ms FORREST - When you read through it, we should do this for everybody. If you are the patient and you have things you want returned, put your name on them. Simple in many respects, but it saves a whole heap of problems that could happen.

CHAIR - Robyn, is there any extra complexity when private health insurance companies become involved?

Assoc. Prof. WALLACE - They do not fund any of the disability support.

CHAIR - At all?

Assoc. Prof. WALLACE - No. They will fund the hospital, physician and surgeon costs et cetera but they do not fund the disability supports.

CHAIR - Okay, so there is no extra complexity there?

Assoc. Prof. WALLACE - No. I cannot see whether it is worth a fight making application in this day and age where they are cutting back.

Ms FORREST - They would argue the NDIS should be covering this and we pay the levy.

Assoc. Prof. WALLACE - Through our advisory group, the agency response from the top said on this that they will fund the admission and discharge processes and one hour a day; the rest they will not fund and most people will need more disability support staff per day.

Mr FINCH - Is this a developing situation though that might be reassessed in the fullness of time?

Assoc. Prof. WALLACE - This is the particular problem the advisory group tackled, about hospital funding of disability supports, and they have come back with that and we have accepted it because the view was you can argue black and blue where the line is between disability and health - the NDIS says that is health, and Health says that is disability. So we said you need a shared responsibility of costs of the disability supports; we need a shared approach. The NDIS have come back and said they will fund the beginning and the end and one hour in between and the National Health Funding Body will probably fund the extra bits. It is all Commonwealth - it is just one pot or another. The health costs will be increasing our education and perhaps some support services.

Mr FINCH - There is a pot there - that was good to hear.

Assoc. Prof. WALLACE - And it is national.

Mr FINCH - Something that you said, Robyn, concerned me to a certain extent. You might care to elaborate a bit on it: the lower quality of health care. Did we cover that in respect of the training? Is it this lack of training of staff that might make them not be able to embrace the issues as strongly as perhaps they should?

Assoc. Prof. WALLACE - It is part of the whole world's approach to people with disability in them being devalued, wrongly. Fantastic doctors would wrongly assume that a person with intellectual disability has no quality of life, and therefore when they get a urinary tract infection at

30 years old, it is not worth treating and that develops into sepsis and they die. A 30-year-old medical registrar with a urinary tract infection - you would not blink an eyelid about treating. It wouldn't cross your mind not to treat it. Incorrectly doctors and health professionals do not understand that these people are loved and cherished, and that they contribute to the world. You don't even have to justify their being alive; they are alive and that is enough.

CHAIR - They are individuals who need as much respect as anybody else on this globe.

Assoc. Prof. WALLACE - Absolutely. That is where the lower quality of care comes in, where they are given a nihilistic sort of approach that they do not have any quality of life. Or it is damn difficult because we don't have the supports there. They are on their own, they cannot talk, the disability sector is not there - they have let them down. Or they are too busy and the reasonable adjustments to the hospital service are not there. There are a number of levels where the lower care ends up being given and the outcomes are severe.

Mr FINCH - Can you see a pathway through as to where that might improve?

Assoc. Prof. WALLACE - Yes, I can.

Mr FINCH - Through that training?

Assoc. Prof. WALLACE - Yes, training, through getting the disability sector on board because it is both - we need the health sector and the disability sector together. We need the disability supports there. We need a better attitude. We need a better support to have the reasonable adjustments in the way we do our work, the organisation of our work and the outpatients. We need our colleges to give us more training. We need the Government to stand up with a loud voice and say this is not good enough for our vulnerable Tasmanians. We have to do better. It is not as if we do not have the capacity or quality. We do.

CHAIR - We have a couple of minutes to go. I am interested in one of the remarks you made in your opening statement, and you made it in your submission as well. Under point 5, with respect to the deaths of patients with intellectual disability, you say that they are not routinely reviewed by the coroner as is the case in other states -

Assoc. Prof. WALLACE - No, that is my understanding.

CHAIR - Do you want to expand on that at all? Does this happen very often?

Assoc. Prof. WALLACE - Too often. As I say, I have a pile of my notes that I read in the *Mercury* and I think, 'There is another patient gone' and I had seen them maybe in my SHAID Clinic not that long ago and I had not expected them to die.

CHAIR - In your what clinic?

Assoc. Prof. WALLACE - SHAID - Specialised Healthcare for Adults with Intellectual Disability. I call it the SHAID Clinic.

CHAIR - Just for the record.

Assoc. Prof. WALLACE - The life expectancy is similar to people with mental illness. It is up to 30 years lower than the general population and the gap is increasing. It is not inevitable. People do not die because of the intellectual disability.

CHAIR - I was going to say, it is not related to their condition.

Assoc. Prof. WALLACE - No. There are a few neurodegenerative conditions, which means they decline with age. People with Down syndrome in their 60s can get dementia or Alzheimer's disease. Over time, that is a terminal disease.

CHAIR - Is it at a higher rate than the normal population they get dementia?

Assoc. Prof. WALLACE - Yes, it is at a higher rate. Not everyone gets it. In people with Down syndrome, there is mild and there is severe. Dementia does not mean you do not give anything; it depends on the level.

There would be a value in having a register. The New South Wales Ombudsman does a report each year, or every couple of years, on deaths of people with disability in care. That can be in hospitals, in hostels or in group homes. It is startling and horrifying that it has been the same report for 10 years or more of the statistics, the causes of death and the reasons for the preventable deaths.

Ms FORREST - Usually it is not overlooked diagnosis, isn't it? It is an aspiration or choking, or something like that.

Assoc. Prof. WALLACE - Yes, or the carers didn't recognise the illness.

Ms FORREST - Or the patient couldn't articulate what they were feeling.

Assoc. Prof. WALLACE - Yes. They are good reports to read. The latest one also brings in the NDIS. Tony Bell and company should take this on and be given the resources to look at this. I have approached our Ombudsman and the coroners.

CHAIR - Tony Bell?

Assoc. Prof. WALLACE - He is the medical officer with the Coroners Court, and there is Philippa White at Health Complaints, the Office of the Ombudsman. I have talked to them about looking into the deaths of patients with intellectual disability. They are keen and they recognise the problem; it is a matter of resourcing. But they are there to be used in learning experiences and how we improve the system, prevent deaths and take action as they would in any other preventable death.

CHAIR - Our time is up. Thank you very much for taking the time to come in. It has been a most enlightening submission. It is always important to make sure that those who are less able to speak for themselves have an advocate and it seems you have done that today. Thank you very much for that, Robyn.

Assoc. Prof. WALLACE - It is terrific to have had this opportunity and terrific that you put out the ad to listen to people. I am very keen to be contacted again should you wish to follow up anything. Consider me as a resource.

CHAIR - That is very much appreciated. To remind you, anything you have said today has parliamentary privilege but if you say anything outside this hearing, that is not afforded to you.

Assoc. Prof. WALLACE - Thank you.

THE WITNESS WITHDREW.

Ms EMILY SHEPHERD, **Mr SCOTT RIGBY**, **Mr TOM MILLEN**, **Ms ANONI MORSE**, **Ms MANDY GLANN**, **Mr JAMES LLOYD** AND **Mr ANDREW BRAKEY**, AUSTRALIAN NURSING AND MIDWIFERY FEDERATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the hearing. All evidence taken at the hearing is protected by parliamentary privilege, which you may well be aware of because of your previous visit here, but I remind you that any comments you make outside the hearing may not be afforded the parliamentary privilege you are afforded today. The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available. We are being broadcast today, and it is a live feed. The procedure we intend to follow is that you will provide an opening set of statements - if there is more than one of you, that is fine - and then members of the committee will be able to ask questions.

Ms SHEPHERD - Thank you, Chair. I extend, on behalf of ANMF and members, our thanks for the opportunity to appear again today. We read the interim report with interest and we would like to elaborate somewhat on progress in relation to the key findings of your report. We have members here from around the state, from the north-west and the north - perhaps we did not have the opportunity to have those members last time - to give more of a statewide perspective. Our members have key interests they would like to represent to you today. If you have questions in relation to our original submission or our updated appendix in relation to those particular areas, our members are representatives from that update.

In relation to providing a brief overview in terms of update pertaining to the key findings and further extending on key matters for nursing and midwifery, as well as emerging issues since the last committee was convened, from the outset, ANMF agrees with all the key findings and certainly welcomed those from the interim report.

In relation to key finding 1, concerns regarding leadership structure and communication with the THS, obviously that was a significant issue in 2017. We have seen significant changes since then, with the passing of the new Tasmanian Health Service Act. The Department of Health and Human Services secretary is now the purchaser and provider of health services within the THS. The ANMF has always been supportive of the return of local decision-making to clinicians at the coalface and within local regional areas. Having the opportunity to have input into that, we certainly welcomed and supported the legislation.

The concern that ANMF holds now on behalf of members is that while the removal of layers of reporting and governance structures has been enabled through the new legislation, the THS executive does not allow for direct input from nursing and midwifery leaders. There is a distinct lack of clinical input and members believe that is disadvantaging nurses, midwives and patients as it removes the clinical context from decision-making and the clinical risks associated with providing safe and quality patient care.

Given nurses and midwives are the largest group of health professionals in the Tasmanian Health Service, it is perplexing as to why they wouldn't have a voice at that executive level. We support the removal of layers and layers of decision-making. It is important that the decision-making is as direct as possible to the actual clinical area, but it needs to be representative of business decisions in relation to budget and needs to consider the nursing and midwifery professions and the impact on patients.

The ANMF is also of the view that the decisions that have gone through THS executive and decisions around key clinical issues in relation to staffing in recent times - for instance, with our re-benchmarking processes - may have been made purely on budget alone. There is no consideration on the impact of staffing and there is no consideration of the flow-on effects that not supporting increased staffing levels have on patient care.

We currently have around seven live workload grievances across our Tasmanian Health Service in relation to unsustainable workloads and the inability of our members to be able to provide the quality of care they would like to be able to provide. This highlights that there is agreeance for increased staffing numbers of nurses and midwives at a local level, even during some of those grievances and re-benchmarking processes occurring, but when the business case is going up to executive, it is not being supported because it does not fit within the 2 per cent Health budget, which ANMF views as completely inadequate.

In relation to key finding 2, access block and overcrowded emergency departments, I am not going to speak about that too much. We have a representative here from the LGH ED, who I am very keen for you to hear from directly, and a representative from the Royal Hobart Hospital as well. However, access block and overcrowding in the emergency departments continue to be a significant issue for our members and the Tasmanian community. In this last week, the LGH had one of the worst 24-to-48 hour periods in terms of overcrowding, ramping and bed block. At one particular time, there were over 60 patients in the emergency department at the LGH, eight ambulances ramped and the waiting room was full.

Ms FORREST - What is the real capacity of an emergency department?

Ms SHEPHERD - Sixty is absolute maximum but there were also eight ambulances ramped at that time as there was no available trolley or bed in the department. There were eight ambulances ramped with patients on ambulance stretchers and also category 2 patients in the waiting room, five of those who obviously need to be seen within 10 minutes of presentation. One of those patients waited 45 minutes. Our members were having constant discussions as to how those patients could be resuscitated in the waiting room and where they would get the equipment from because they did not have a bed or a trolley to put a patient on if they collapsed in the waiting and all resus. beds were full. That is one example and there are similar issues in the Royal Hobart Hospital.

Adverse outcomes for patients have resulted as a direct result of overcrowding in the emergency departments and increasing pressure on staff to discharge patients, not only from the emergency department but also from inpatient wards and units. We are aware of two incidences where members are of the view it has contributed to patient deaths. One particular patient was discharged from the emergency department and returned within the space of 24 hours and was pronounced dead on arrival back at the emergency department. Obviously, those issues are being investigated by the coroner but certainly members' perception is bed block and overcrowding has contributed to a patient death in terms of the pressure on ward staff, nurses and midwives to discharge patients sooner.

There is also another incident where a patient who did not want to go and was discharged from a ward area when staff felt they should not have gone home. The patient was discharged and died within 24 hours upon discharge. Again, this is being investigated by the coroner but certainly members feel the pressure in relation to bed block and early discharge has contributed to those patient deaths. Since then we have had a number of industrial campaigns. I will let Tom

speak to that further in relation to the LGH emergency department. We know solutions are available to assist in emergency department overcrowding and bed block at Launceston General Hospital. Our members launched industrial action from the emergency department in March this year and put up a raft of positive solutions that could assist with bed block and aiding patient flow at the LGH.

Three of those recommendations were to utilise additional bedspace or beds within the LGH. We constantly hear from the Tasmanian Government all wards are open and this is true, they are all open, but not all the beds are open, fully funded and utilised. Ward 4D currently has 19 beds fully funded as a result of ANMF taking unsustainable safe workloads to the Tasmanian Industrial Commission. On behalf of members, we were able to secure funding for 24 beds for a six-month period with staff employed on a fixed-term contract for six months. Those bed numbers have been increased to 24, but during the last 24 to 48 hours those additional beds have been reopened to assist with the crisis in ED. Those beds have been consistently open since December last year and have been staffed by agency staff, casual pool staff and predominantly by staff currently employed permanently to Ward 4D for the 19 beds through double shifts and overtime to tune of over $100 000.

The business case through that grievance was in support of full funding of the full 29 beds, not only to assist obviously bed flow and patient flow out of ED, but at assist with skill mix. The patients going into those unfunded additional beds were staffed by double shifts and agency staff who did not necessarily have the appropriate level of skill. It was adversely affecting skill mix on the ward and staff were struggling with seniors providing the support to less experienced staff and caring for incredibly acute patients.

Other priorities and strategies suggested by ED staff were opening beds on Ward 4K. There is the capacity for additional beds on Ward 4K. That was supported through a business case and re-benchmarking at the local level between ANMF and local management. There is still no outcome on that business case. It has been identified that beds in ICU, additional capacity in ICU, could accommodate more patients. Management at the local level has not been able to support that due to budget constraints and the cost associated with opening up two ends of the Intensive Care Unit.

CHAIR - Are you talking about the Royal Hobart Hospital?

Ms SHEPHERD - I am talking about the Launceston General Hospital.

While the Royal Hobart Hospital has its own challenges within it current footprint, we also know K Block will be commissioned by October 2019, if that continues on the projected time frames. Last time we appeared, we spoke in relation to some of the challenges around the decant but we know that the removed K Block will come with its own challenges. It will not be the solution that it might perhaps be perceived to be.

Ms FORREST - Is that J Block or K Block? Are they moving J Block?

Ms SHEPHERD - It is K Block. No, K Block is the new building.

Mr LLOYD - J Block is the demountable out the front and that is staying where it is until 2025.

Ms SHEPHERD - As to the wards and units moving to K Block, the bed numbers are staying the same. We understand, through the redevelopment team, there is a potential capacity for around 50 to 60 additional inpatient beds. We have called upon the Government to fund those beds immediately toward the move in 2019. We understand they have not been funded.

We have also called for immediate funding of stage 2 of the Royal Hobart Hospital redevelopment, specifically noting K Block, renovating and refurbishing the current ward and unit areas to enable additional capacity. Through the budget released by the Liberal Government this year, there is an allocation for investigation and review of the stage 2 proposal but no budget to commence work on stage 2, which is going to be absolutely instrumental in improving bed block and increasing capacity at the Royal Hobart Hospital. K Block won't increase capacity.

I might not cover key finding 4. I would prefer to see Mandy, our representative from the North West Integrated Maternity Service, cover that.

In relation to key finding 5, I have covered the redevelopment. In the last six years, focusing on the Launceston General Hospital, where we know there are potential solutions to bed block, there have been around 1500 additional presentations. We know the number of category 1 and category 2 patients who are presenting are increasing all the time. We know those patients are unlikely to be discharged from the Emergency Department and will require inpatient admission. We are not seeing the increase in capacity in line with the demand for inpatient admission and in line with ED presentations.

In the budget, there are capital works occurring with additional capacity but a lot of those additional capacity and additional beds will not realise until 2022 or post-2022, in accordance with the six-year commitments made by the Tasmanian Liberal Government.

In relation to key finding 6, timely, acute and community mental health care being inconsistent and lacking functionality, we agree there are still significant challenges for mental health patients in receiving access and timely care. In terms of ED bed block, our mental health patients are some of the worst affected in the length of stay in emergency departments. At the Royal Hobart Hospital we have seen mental health patients staying for up to six days or waiting an inpatient admission. The Liberal Government had committed to an additional 10 beds at Mistral Place in its first year plan, which we understand have now been delayed due to engineering issues. As a result, ANMF have called for additional CATT and CAM staff to assist in the community with crisis management and prevention, to try to reduce presentations to the emergency department. There has been no additional increasing FTE in these areas.

In relation to key to finding 7, child and adolescent inpatient mental health is an ongoing and serious concern. Tom would have his hours of that, but what we know is that one particular adolescent mental health patient spent five days in the Launceston General Hospital Emergency Department. That particular adolescent was passed around between medical and psychiatric teams and no-one, up until the date of discharge, took responsibility for that particular adolescent child. It was reviewed by a psychiatrist from interstate and we understand from the report the psychiatrist made following the assessment that it was one of the worst cases the psychiatrist had reviewed. That report subsequently disappeared from that patient's file. Unfortunately, that particular adolescent was discharged from the emergency department without a plan of care being established either by mental health or by the medical team. The adolescent was discharged with services in place, I believe up to 14 services, but the members felt the system absolutely failed that particular adolescent mental health patient.

I will finish up and give our members the opportunity to speak. One of the key findings touched on the workforce challenges the Tasmanian Health Service poses, also in terms of nursing and midwifery professions. We are incredibly concerned about the nursing and midwifery workforce working within acute health services. The Tasmanian Health Service has lots of layers and lots of elements to it. We absolutely need to be sure that we have appropriate government structures and appropriate management and leadership structures in place, resources and plans for infrastructure et cetera. Our view and our members' view is that the Tasmanian Health Service would grind to a halt without nurses and midwives, which are the largest cohort of health professionals working with the Tasmanian Health Service. What our members believe is that the Tasmanian Government is not recognising and valuing and looking at the fundamental need to ensure there are adequate numbers of staff to provide the safe and quality care required of nurses and midwives.

Over the last 12 months, $7.5 million has been spent on double shifts and overtime worked by nurses and midwives. This is on the back of business cases going up to THS executive requesting extra baseline minimum staffing, which have been repeatedly denied or they have been rejected. Business cases have then had to be worked up again to go back up for approval. During that time, it means that nurses and midwives are working in incredibly challenging situations and doing double shifts and overtime just to maintain safe patient care. We also know that up to an average of nearly $2 million a month is being spent on agency staff in our specialty areas to ensure minimum safe patient care.

CHAIR - For clarity, by agency staff, are you are talking about hired-in staff?

Ms SHEPHERD - Yes, locum nurses and midwives.

CHAIR - Some people may think of DHHS staff as an agency.

Ms SHEPHERD - Yes. That is incredibly concerning given that we don't have a workload model or a system currently to support the agreed industrial instrument, in terms of our re-benchmarking process, that enables minimum staffing levels to ensure safe patient care and the safety of our staff. We are very concerned that there does not appear to be any consideration in the Tasmanian Health budget recognising the need for recruitment and retention strategies for nurses and midwives. We know we have an ageing population and our nursing and midwifery professions are not immune. We know from our membership numbers that in the last 12 months nearly 200 members have retired. We are seeing significant numbers moving interstate as well, and we truly believe the Tasmanian Government needs to invest in recruitment and retention strategies and certainly aid in recruitment, but, while we do that, to increase our numbers of nurses and midwives.

We know there are around 250 vacancies, both permanent and fixed-term, within the Tasmanian Health Service. We also know that over 750 nurses and midwives is the target for the Tasmanian Government to recruit over the next six years. We have considerable concerns about how that will be achieved and how the additional health services will be staffed, given the current deficit.

We also know that other states and territories also have similar targets in terms of recruitment and retention because it certainly is not a new proposal. There are going to be significant

numbers missing from our nursing and midwifery professions into the future with an ageing population and increasingly elderly nursing and midwifery profession staff.

I will leave it there for now. I will have some recommendations, probably at the end, that I would ask you to consider. I might open it up to our members.

CHAIR - Before you do so, be aware we have a 12 noon deadline on this because another witness IS coming in, so you will have to leave some time for questions as well. I am not trying to limit you too much, but we do have a time line.

Ms SHEPHERD - Yes. I am finished.

CHAIR - That is fine. I appreciate that. Thank you.

Ms SHEPHERD - I might start with you, Tom, perhaps if you want to give a bit of an overview.

Mr MILLEN - Thank you for the opportunity to come today and speak. I would like to make an apology for my nurse unit manager, Scott Rigby, who was also meant to be here today. Unfortunately, last night he received news about the loss of a very close friend and hence was unable to come today, but I hope that at some stage in the future he will have the opportunity to come before you, because as the nurse unit manager of the LGH Emergency Department, he has an absolute insight into the workings and the non-workings of the department.

I am representing the nurses in the Emergency Department at the Launceston General Hospital. My colleagues and I have been under extreme stress for some time. For well over a year now we have seen bed block and ramping becoming an almost daily occurrence with very little reprieve, and it is actually taking a physical and emotional toll on frontline staff.

We are a very resilient workforce and we are a great team. We do our best, but we are being pushed beyond what we should have to deal with on a daily basis.

We have, as a group, decided we needed to plead for help, essentially. As Emily alluded to, in March we created an industrial campaign to bring attention to the issue of access and bed blocking in the Launceston General Hospital. We felt that our pleas were not listened to, or we were really not getting very far with what we had requested, so 72 days ago we increased our industrial action by coming to work early, on our own time, before a late shift, to commence a vigil outside the Emergency Department. This is all staff not at work; this is not a strike action. We are coming on our own time because we could not afford to allow patient care to be compromised any further.

For 72 days, throughout winter, we have been on the street every day, pleading for help. We initially received very little response from middle and upper management. Our department and our nurse unit manager and our director of medicine in the Emergency Department have been fantastic, but with everyone above that we have really had to drag them - not quite physically, but almost to shame them to come. Whether it is at the level of middle and upper management of the THS or at the ministerial level of government where the main failings are, it is not for us to make that decision or that call. There is clearly a failing here; the system has failed.

We have not received adequate responses from the THS executive or from the levels of government to address these concerns. As Emily alluded to, we have been putting solutions on the table, some of which probably would be quite cost-neutral, to make improvements. We have had some initial meetings now, finally, but by no means are they adequate. My colleagues feel we are really not being listened to. There seems to be a disconnect between the executive and the frontline workers, who are dealing with the trauma every day of caring for very unwell patients in inappropriate situations.

The situation is that a person should present to the Emergency Department and within four hours either be cured and discharged home, or be admitted and sent to a ward. We are seeing people spending days and days in the Emergency Department essentially blocking a bed so that we are not able to function as an emergency department. We come on in the morning and maybe there are one or two beds free to see all of the people who will be coming in through the day. It is fundamentally unsafe. The levels of stress, anxiety and depression among my colleagues that they have come to me about and that I know about is scary, and what I don't know about - it is probably the tip of the iceberg.

There is immense stress on frontline staff. I want to give you a couple of quick examples. Emily has spoken about the horror stories. There are horror stories almost every day of elderly people being left in the waiting room and having to be treated for pain management and invasive treatments at totally inappropriate levels, giving their personal and confidential medical histories sitting next to a total stranger. It should not be how this system works. I am sorry, it is emotional, and I know we have a time limit, but I would rather focus on some of the fundamental things that we can change.

Ms FORREST - I heard an interview on the ABC and I don't know whether it was with you, Tom, or whether it was with Scott, talking about some of the possible solutions you have put forward. Are you able to provide the solutions that you have put forward to the committee?

Mr MILLEN - We can provide those.

Ms FORREST - It has been very clear there are serious challenges here.

CHAIR - As an addendum to your submission.

Mr MILLEN - Yes, we can and also we can supply the responses we have had from the Government. As a clear example, at the moment, we have a position where we have not had a medical discharge team available on the weekends, so when you have a patient whose condition has improved so they are able to be discharged -

Ms FORREST - From the ward?

Mr MILLEN - No, from the Emergency Department, and from some wards as well because it is the same situation. You have a position where there are no doctors available to do that discharge; you can have a person who is essentially cured, holding up a bed until Monday afternoon, potentially, exacerbating this problem.

CHAIR - They have been there over the weekend?

Mr MILLEN - Yes, and essentially could have been discharged, but there was no-one to do the discharge. We know that there has been a business case put forward again to the executive for this. This beggars belief, if the public had knowledge of this incompetence - and that is what it comes down to. We are not a Monday-to-Friday hospital; we are a 24/7 major hospital and we should be treated as such. I really could talk for hours but my colleagues are here have equally important issues. If the committee has an opportunity to come to the Launceston General Hospital, we would be very grateful to meet and maybe you could even hear from some of my colleagues if it would be helpful for you. We would appreciate that.

CHAIR - We have visited, but we have not specifically visited in the circumstances you are talking about.

Ms FORREST - Very difficult to visit the DEM when you are in the circumstances you are in. The last thing you need is people like us.

Mr MILLEN - If you give us some notice, we would make ourselves available. We really want to change and improve things and do think we can have a major role. As Emily alluded to, there is not a nursing voice on the executive fundamentally -

CHAIR - Thanks for that, Tom. The suggestion of putting in an addendum of where some of the solutions lie is a good one.

Ms GLANN - I am a midwife in the North West Private integrated maternity services, which has been running since November 2016. We have many varied issues, most of which relate to original poor set-up of the service. I work with a group of really dedicated midwives who have stayed with the service when it was integrated and are feeling fed up and have low morale. Most relates to the integrated part of the service, which is not so integrated and having a public and private contracted service which does not work together. Part of the problem is the contract committee and the management at that level. There is nobody from the THS - and I make it clear I am representing the midwives from the THS, not from the North West Private - below the CEO level who can feed back information and take information to the committee. Basically information goes with the problems and things that need to be worked out and there is no feedback and nothing seems to be changing.

Ms FORREST - There is no midwife on that committee, Mandy?

Ms GLANN - The director of nursing at the North West Private and the nurse unit manager of the North West Private are on the committee, but from the THS perspective, it is the operations manager and head of clinical operations.

Ms FORREST - Who are not midwives?

Ms GLANN - No, it is high level management and the CEO and the don of the North West Private - sorry not the [inaudible], but the North West Private. This is a major issue, because we know things are happening that could and need to be sorted. Part of the problem is staffing across both services. We are constantly running with agency staff to keep enough staff in the THS service. The North West Private Hospital is short staffed and running on a number of agency staff. A recent issue was a change to service. Management said it was not a change to service but it was. When the integrated maternity services were set up, we had a resident medical officer stationed at the Mersey, the only continuous medical officer stationed there. The position was

initially taken away, but we initiated industrial action when consultation did not get us anywhere and the position is now back, but in a sideways form.

That was said because of RANZCOG requirements and is probably true. The RMO position in itself is not the biggest problem. The biggest problem is when they took away the RMO position; they took away our ability to do assessments, because nobody was looking at midwifery practice and what midwives could do. So they said any women from the Devonport area of the north-west could not be assessed at the Mersey and everybody had to go to Launceston or Burnie.

Ms FORREST - Are you talking about antenatal assessments?

Ms GLANN - Yes. If somebody rang and said they had not felt their baby move for two hours, we had to send them to whichever hospital they planned to birth at. That created problems with people not going because they did not have transport, people ringing their intended birth place and being told they could not see them because they would be waiting for hours. Three or four women who presented to the private hospital were turned away because they did not have the staff to do an assessment and were then sent to the North West Regional Hospital Antenatal Clinic. They had gone from Devonport to another area in Burnie. Staffing is an issue and they are not set up for doing this extra work. Nobody appears to be looking at this and how it can be better set up to work in an integrated fashion.

CHAIR - Does this have repercussions for the training of midwives in the public system?

Ms GLANN - It has. We have a lot of issues with recruiting and retainment of staff because there is nothing to attract midwives to the area. If you work for the THS, you can only do antenatal care or postnatal home follow-up. If you work for the North West Private, you can only do birthing and inpatient postnatal care. Currently, any of our staff who are still working for THS who want to do birthing around their scope of practice, we have midwifery group practice which employs seven midwives and they can do it. Otherwise people have to have two contracts. They have to have a contract with the North West Private and a contract with the THS. That creates problems.

Ms FORREST - As with Tom, do you have a range of possible solutions for this?

Ms GLANN - There have been discussions and negotiations and the general feeling among the members is the only real solution is to take all public services back into the THS.

Ms FORREST - Do you believe that is a viable option?

Ms GLANN - Yes.

Ms FORREST - There is a contract with the private provider at the moment but now it is finally not an evergreen contract. Do you think this is something that should be looked at as the next step and how would you progress this?

Ms GLANN - In 2020 it looks like a purpose-built antenatal clinic at the north-west region will be constructed. We suggest it should be built somewhere where there is space to add birthing services when the contract is up. The other thing is getting clinicians or at least a director of nursing or a [inaudible] from the THS services on the committee for the contract. At the moment it seems there is no accountability. There are issues with documentation where patients go to

North West Private and nothing gets documented on the combined system for obstetrics, and when they present to their next -

CHAIR - It is disjointed between the two services.

Ms GLANN - It is very fragmented and disjointed mainly due to staffing. It is basically a private service that wants to make money.

Ms FORREST - Are you aware of any adverse outcomes as a result of disconnect between the public and the private service?

Ms GLANN - Not that I could talk to off the top of my head. It is mostly people arrive, they cannot be seen and they get sent elsewhere.

Ms SHEPHERD - One was raised with me in relation to a patient who was flagged as high risk and needing support with management of the baby post-delivery in relation to substance abuse. There was fantastic documentation, risk assessments and a plan documented by the midwives and the THS in an antenatal setting. When the child was born in the North West Private, there was disconnect between recognising the information and the woman and baby were discharged home, without the plan of care implemented. They were picked up by midwives from the THS in a postnatal setting with a home visit as not having had the plan of care implemented. It was lucky there was not an adverse outcome for the baby.

Ms FORREST - This service was allegedly integrated for better patient outcome.

Ms SHEPHERD - Yes. We believe, and our members believe, that it has fragmented the services; there is much less continuity of care than there ever used to be before. It has probably improved as far as extended care in the Burnie region because we have a stable workforce of two staff, who are basically covering that all the time. That has improved a lot but it has certainly fragmented it more in the Mersey region.

We are currently having issues around inductions of labour. The recommended post-date inductions are that women should be induced at about 41 plus three days. It seems that women are currently being induced early because people have to book a spot and they can only do so many inductions a week. If they wait another week, they will be past 42 weeks. People are getting taken into hospital and being induced earlier and probably unnecessarily because they do not have the staff and they do not have the beds to fit them in.

We have issues all the time around the midwifery group practice working longer hours than they need to. This is out of hours as far as their patient care goes. They have to do cleaning out of hours and they cannot leave until they have cleaned birthing suites, so we are paying very highly qualified midwives good money to be cleaners. That is causing a lot of angst between MGP midwives and core midwives in that service. One believes they should be doing one thing and the other believes they should be doing something differently.

They do not have enough birthing suites to allow those women on midwifery group practice to stay in the birthing suite, have their eight to 12 hours in hospital and then be discharged straight from there. They need to be moved out no matter what time they are birthed and all of that must be cleaned up ready for the next. They are really busy all the time and the midwives at the North

West Private are run off their feet. They are as disenchanted with the service as the THS midwives are.

CHAIR - Thank you for that. I appreciate that rundown.

Ms SHEPHERD - In relation to Mandy's statement, during our last appearance the minister followed our presentation and reiterated that there was an evaluation and a review occurring. To date, we have not seen the report or the recommendations from that review. We understand it is complete and that was one of the reasons midwives in the north-west instigated the industrial campaign. They are very intent on improving and maintaining the quality service they manage to provide in challenging circumstances, but there is no urgency around looking at those recommendations and implementing them to improve service.

Ms FORREST - Hopefully the minister or his staff are watching and he might bring it when he comes to the committee. He will be asked for it if he doesn't.

Ms GLANN - Can I also add that our co-director of nursing resigned recently. We currently have people in acting NUM positions and acting co-director of nursing positions. One of the reasons she cited for resigning was that lack of authority and inability to make anything happen; consistently taking things to the contract committee, asking for things to be changed, asking for things to be followed up, and nothing ever happening.

CHAIR - Thank you, Mandy.

Ms SHEPHERD - We can go to James, but I am conscious of the time and I wonder if there are questions you might like to ask before we do that?

CHAIR - James, how long are you likely to take?

Mr LLOYD - I can be really quick. One of the points I wanted to make about the Royal Hobart Hospital ED and the Royal Hobart Hospital in general is that there have been an extra 10 acute and 20 non-acute beds opened. We welcome that and that is fantastic. I am the bed manager at the Royal Hobart Hospital and what really scares me is, despite those beds being open, I can be on an evening shift seeing ED with 70 patients and 20 people waiting for beds and we are not even in the flu season. The flu season has not happened and we have had 30 beds opened. If you think of where we would be, that is a dangerous situation. If we didn't have those beds, it would have been even more dangerous, but we are still in a dangerous situation.

It is almost like we have built this capacity but we need more planning for more capacity because it is still dangerous and we don't have the flu season. I wanted to make that point. It is still scary at the Royal Hobart Hospital. When I was the bed manager last Tuesday, I sat down and I still had 20 patients who needed beds in the morning. We still didn't have the capacity. We got them into beds by 3.00 p.m. but then we used up all those discharge beds.

CHAIR - What time of the morning are we talking about?

Mr LLOYD - I come on at 7.30 in the morning. I sit down and there are 20 people overnight waiting for beds. By 3 p.m. we have cleared ED, but we have used all the capacity from our discharges and theatre cases that had to go in, and so we go into the afternoon, where we have very little or no capacity to take care of the afternoon's patients. As Tom talked about the LGH,

this is an ongoing issue for us. It is not safe to have people waiting for so long in ED for beds. We need more forward-thinking, we need more built-in capacity and the staff need to be listened to.

Ms SHEPHERD - I just want to add something in relation to what James said about bed block. Just this week, when we saw the situation we did at the LGH, we also understand that there was no cancellation or slowing down of elective surgery. That continued as normal. I also understand there was no rescheduling of non-urgent angio cases as well. There were patients transferred from the north-west coast to the LGH needing angio surgery, but not urgently, who were ramped in the backs of ambulances. These patients went into cardiology beds ahead of someone who had been waiting in the Emergency Department and had presented with chest pain and STEMI. Again, in that situation, from our perspective, it appears there is no regard for the staff who are having to deliver patient care. The only deciding factor about how to proceed with delivery, for the THS and certainly for the Government, is the budget. We know that elective surgery is incredibly important in generating health funding -

Ms FORREST - Activity-based funding is what it is all about.

Ms SHEPHERD - Exactly, activity-based funding, and that goes ahead of the risk to our members and also the risk to patients in emergency departments. If I can make one point today, it's that it is time the Tasmanian Government recognised the impact that its health service and lack of adequate resourcing and funding is actually having on the nursing and midwifery workforce, and the flow-on effect that has to patients. It is not best care to be delivering care to a patient when staff have been working for 18 hours, or they are having to deliver it to a patient in a waiting room who is on the verge of collapse and there is absolutely no equipment and no bed to resuscitate them on.

CHAIR - From an operational perspective, you mentioned in your submission that the relationship between your staff on the ground in the hospitals and the staff of the ambulances that are coming in having to be ramped, can you briefly say how that is going, for the record?

Ms SHEPHERD - Yes, there is no doubt it is a strained relationship. Our members work incredibly hard to try to foster a collaborative relationship with Ambulance Tasmania, but they recognise from ambulance staff that the longer they are in an emergency department with a patient, the longer a patient in the community is waiting for a first responder to an emergency call. They absolutely understand that. I also understand that Ambulance Tasmania recognises when an emergency department is overflowing and there is no room at the inn, that the staff are doing the best they can but there are no available options. Nonetheless, it does create friction and there are competing demands. Everyone is there for the right reasons but, again, the system -

Mr MILLEN - From a personal perspective, and having to work in this environment, when you are under extreme stress trying to deliver adequate and safe patient care, when there is this added element of having an unnecessary potential conflict with your colleagues from the Ambulance Service, this is just not good enough. This is phenomenal failure of the minister; if he cannot deliver appropriate policy for a cohesive relationship between frontline nursing and paramedic staff, then that is a big cross.

CHAIR - Thanks, Thomas.

Ms FORREST - Do the other two want to say anything you have not covered?

Mr MILLEN - Not at this point, no.

Ms MORSE - The only thing I would add about the situation at the Royal Hobart Hospital and Launceston General Hospital is that it does have a ripple effect and impacts on the Mersey Community Hospital and the North West Regional Hospital because it becomes difficult to transfer people out and then there are delays in accessing care. It is a system-wide issue where the critical incidence focus at the moment is on the LGH and the Royal, but it does have a ripple effect across the entire health system.

CHAIR - Thank you for that. James, if you wish to take up the same offer we made earlier about putting some solutions to us, we would be happy to receive those for consideration by the committee.

Mr LLOYD - Yes, we can do that.

Ms FORREST - I appreciate your putting the new submission in. Much of the previous evidence we received was focused on the Royal because it was a bit of a hotspot at the time, but it is clear this whole system has to work in an integrated way. I hope we will have the minister before the committee at some stage, so the solutions you put forward and the responses you have would be really helpful, and also any other questions you have for the minister. If he were sitting here, what would you ask the minister about dealing with some of these very real challenges that you are facing?

Ms SHEPHERD - Not for this committee, but we are engaged currently in our 2018 public sector nurses' and midwives' negotiations. The fundamental basis of that log of claims for our members is in relation to recognising the current workforce and also recruitment and retention. We have not been able to reach an agreement and a lot of the claim items have not been supported. The question we have asked in that forum is: if the Tasmanian Government is not going to adequately resource the service by providing sufficient funding to enable adequate staffing on every ward and unit, and adequate staffing to provide safe and quality care to excessive numbers of patients in the Emergency Department because bed block has not been resolved, or if the bed block issue is not going to be resolved in a timely way, we know at the LGH that the 4K extension is going ahead and will be available next year, but underneath the 4K extension there is going to be an empty shell of space that will not be fitted out for use when it could be fitted out for use and could come online soon or enable a whole ward, Ward 3D, where the antenatal clinic is currently, to be operating as an additional ward space, how is the Tasmanian Government going to ensure that enough nurses and midwives remain in the Tasmanian Health Service to keep the health service functioning? Ultimately, our members are saying enough is enough.

The Tasmanian state election this year was really held up as a pinnacle that this is the answer to the health crisis and urging people to vote for the party that is going to deliver on actual solutions to this problem, but our members have been waiting for those solutions to be implemented. It is a six-year plan and most of them will not be implemented until 2022 - what do our members do in the meantime? We can't continue to see our members propping up a health system with double shifts and over time and working in unsafe environments - they give 110 per cent every time to patient care, but at some point even their best is not going to be good enough.

Ms FORREST - This is perhaps something you can comment broadly on. We have seen a lot of changes over the years in, say, elective surgery - not so much in Tasmania, but the Mersey could be an example where this could be more effective. You have standalone day surgery units - you see them in Victoria and other states all the time - and those free up sections of the acute hospital, potentially. We have seen changes in the DEM. When I was working in these places, which was some time ago now, we didn't have emergency medicine specialists, senior doctors, there running it; they were just called in when they were needed, but now they are there. Correct if I am wrong here, but we don't seem to have seen that same approach given to medical patients - and this is often where the bed block occurs. You have medical patients holding up the beds on the wards. Do we need to look at a different way of doing this and is there is a solution to that as well?

Ms SHEPHERD - We absolutely support it. In the 2016 agreement we were able to secure commitment to associate nurse unit managers. Within their statement of duties, a large component is patient flow and discharge planning assessment, early intervention referral and facilitating discharges and enabling patient flow. That was only agreed if it was FTE-neutral. A lot of those people in those positions across the state still carry a full patient load and they are still trying to be an ANUM at the same time.

Ms FORREST - You believe there needs to be a separate position that manages at a higher level?

Ms SHEPHERD - Absolutely, and have called for criteria-led discharge from a nursing and midwifery perspective. Repeatedly that not been implemented. There is no doubt a medical base team to facilitate patient discharge in each medical ward would be helpful, as Tom said, over the weekends, being a 24/7 model.

The real issue is we absolutely need to have those positions in there. We have called for nurse navigators, we have called for additional staffing, but that will come at a cost and we don't believe any initiative that is going to create an additional cost or burden on the already formulated Health budget put out by the Tasmanian Government will be supported.

Ms FORREST - I hear what you are saying. If you can clear beds, not have this backlog and not have other flow-on costs of adverse patient outcomes, are we talking about a false economy?

Ms SHEPHERD - Yes, absolutely, but I would put to you, Ruth, that you understand that as a clinician. When you have people at the THS executive who are making decisions based on a business model, what you get is a business model health service. You do not get a health service that is based on patient need, clinical risk and adequate efficiencies.

In terms of efficiencies, I will pick up on your previous point. Those positions are helpful in terms of patient flow et cetera, but the Australasian College of Emergency Medicine is equally clear that we need to be efficient and we need to encourage patient flow with nurse navigators, ANUMs et cetera. You can only be so efficient and our members are also tired of being told they need to be more efficient. You can be as efficient as you like, but if you don't have enough beds, it is not going to improve the situation.

Mr BRAKEY - You mentioned adverse outcomes, Ruth. We have seen evidence recently that our senior nurses who are on call for hospitals overnight, the evidence suggests about 20 per cent of their calls are for SAC 1 and SAC 2 level incidents. That is our safety reporting system.

A SAC 1, SAC 2 could be where a patient has either died or has had a serious event of injury. That was over a two-week period. There were about 116 calls in total and about 20 to 25 of them may have been for SAC 1, SAC 2 over a two-week period.

Ms FORREST - You will provide some of this information about what you have suggested.

Ms SHEPHERD - Yes.

CHAIR - We are over time. I appreciate we could be here for hours to hear this. It is very much appreciated that you have put it down in writing. My concern is with respect to your members. What is the situation with their health and welfare? How is that handled? Is it being handled efficiently or effectively, from your perspective? I realise you are a federation and you are going to have lots of comment on this, but I would like to know how staff are supported and what you hope to have put in place toward their health and wellbeing.

Ms SHEPHERD - There is no doubt nursing management at a local level is giving their staff 110 per cent support within their capacity and available resources. The nursing manager, having spoken to him this week, said to his staff, 'I am available after hours. If you need someone to talk to, you can ring me'. He is getting two to three calls a night to support his staff in that department. Fundamentally, the issue is that they do not have enough staff in that area because of presentations and the bed block issue isn't addressed.

CHAIR - Has that level of support you are talking about, two or three calls overnight to somebody who has offered to do that, been increasing over time or has that been happening for years?

Ms SHEPHERD - Nursing managers have always done that because they care about their staff, but it is increasing. I will not talk about the content today. I have had that conversation with Scott but he has not wanted me to talk about the type of calls he is getting in respect to the staff. The issues staff are calling with are alarming. The system is failing staff from a work health and safety perspective. The system is failing staff from a work health and safety perspective because it is not addressing the fundamental challenges of a health service whereby it is not staffed appropriately. The issues around their block are not being addressed despite there being adequate solutions. The system is trying to work within a budget that is completely unrealistic and does not consider any of the risks to staff and patients.

CHAIR - Does it present any issues for staff with respect to mandatory reporting as to how staff are reacting and behaving under these circumstances?

Ms SHEPHERD - Staff, as Andrew has alluded to, are putting in incident reports. They go to Tasmanian Health Service management for review and actioning. Our understanding in terms of advocating for our members in these situations, even going to the commission - one event being Ward 4D in which beds were shut because of work health and safety issues relating to skill mix and unsustainable workloads - are that those beds will reopen because of demand, yet elective surgery continued and non-urgent angio continued. That shows the complete disregard for staff and their wellbeing. If I can get one point across, the Tasmanian Government relies upon nurses' and midwives' goodwill to prop up a health system that is failing.

CHAIR - Thank you.

Mr FINCH - A lot of the evidence we have heard this morning has been really concerning. One element was the disconnect between yourselves and upper and middle management. One point you made, Thomas, I wanted to note was your talk of 60 in the ED department with eight ambulances ramped. That is just frightening. Why wouldn't people we are trying to recruit to come into the state look elsewhere when they see that situation? They would think, quite rightly, 'I am not going into that world of stress'.

Mr MILLEN - It is a question that should be asked. If you go to the myhospitals website and put in Launceston General Hospital for length of stay in an emergency department, which we know is a key indicator of adverse or positive outcomes, we, the Launceston General Hospital, are the worst of comparable regional hospitals across Australia. We have the worst length of stay and we are probably going to be the lowest paid. What sort of an incentive is that, really? I don't need to say any more.

CHAIR - Thank you very much. We do need to wrap up. I want to thank you for presenting to us again. The evidence you presented previously is carried forward to this re-established inquiry, so you can be satisfied it is all on the record. We appreciate you have come in under very stressful circumstances, the way you were describing it to us, and we thank you for that.

Ms FORREST - Thank you for all the work you are doing at the hospital.

CHAIR - Thank you for that, as well. I am sure a lot of people listening because it is being live-streamed. They will understand you are under immense pressure. I am sure the Government understands that, too, to a degree. It is our duty to put this information together and come up with recommendations. We thank you for your time. To reiterate, anything you have said today has been covered by parliamentary privilege but once you walk out the door it is not the case. You need to be aware of that. Thank you.

THE WITNESSES WITHDREW.

Dr BRYAN DOYLE, FACULTY CHAIR, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED AND **Dr SIMON JUDKINS**, PRESIDENT, AUSTRALIAN COLLEGE OF EMERGENCY MEDICINE, WAS CALLED VIA TELECONFERENCE AND EXAMINED.

Dr DOYLE - Dr Simon Judkins is the President of the Australasian College of Emergency Medicine and hoping to dial in.

CHAIR - Welcome to the inquiry. We are taking sworn evidence today so we ask you each make a statutory declaration. Simon, I believe you have that?

Dr JUDKINS - I may not have that in front of me.

CHAIR - You are not in the state, so you do not have to swear. We are being live-streamed today.

Today, we are in a public hearing for the Government Administration A Subcommittee inquiry into acute health services in Tasmania, which has been re-established after the new parliament. All evidence taken today is under parliamentary privilege, but if you were to speak outside this hearing, that would not be covered by parliamentary privilege. It is being recorded on *Hansard*, it is being live-streamed and it will be published on the committee's website at a later stage when it becomes available. We will open it up for you to provide some lead-in statements and then the members may wish to ask questions.

If at any time you wish to have something heard in confidence, there is the opportunity to inform the committee and the committee will consider it and then may or may not, depending on the committee's decision, go into camera.

Dr DOYLE - Simon, I will let you go ahead.

Dr JUDKINS - Thank you again for allowing us to participate in this inquiry.

As you know, we were previously involved in submitting this time last year and expressed our ongoing concerns around the situation in the acute care sector of the Tasmanian health system. Obviously, our interest is really in the frontline of the healthcare system in the emergency departments and seeing increasing difficulties our emergency departments across the state are having, in particular the Royal Hobart and Launceston General. Sadly, since the last time we spoke, we have actually seen deterioration in what was then a dire situation. We are seeing worsening access block and patients staying longer times in emergency departments in both the major hospitals. We have seen Launceston lose its accreditation as a training site and we are seeing increasing numbers of mental health patients. It is well known to everybody in this meeting we are seeing increasing numbers of mental health patients staying very long periods of time in the state's emergency departments. As we said last time, we are committed to working with the Government and the hospital administrators are trying to improve this situation. We have had some ongoing meetings to discuss how we may address this. We are actively involved in working with the Health secretary and Health minister to try to find some - hopefully short-term - actions, but really how we can put in some sustainable meetings with long-term solutions for the Tasmanian health system.

It certainly is and Bryan will be able to expand on this. From my work in the coalface working in the emergency department, it is incredibly stressful and draining for all the staff involved. It is recognised operating this level of mismatch between resources and demand really puts patients care at a high level of risk, where no doubt it impacts patients' length of stay once they make it into hospital. We have no doubt it increases the amount of misdiagnosis, medical errors, increasing morbidity and mortality, so it is a situation we have to find a remedy for.

CHAIR - Thank you very much.

Dr DOYLE - Yes, I can expand upon a couple of things. If you ask any emergency doctor what is the single biggest challenge, it is when the hospital is full. When the hospital is full and you have patients who are sick who need to be admitted to hospital, you cannot send them home. They stay in the emergency department. Having heard a little of the discussion previously, obviously, you have heard all about access block and bed block. That is the major issue that cripples us.

It is not the walking wounded who come in maybe inappropriately. Some of them do. That is not an issue. That is our problem. We treat them and get them out really quickly. The major issue is the sick people who continue to come. Obviously, we cannot tell them to come and we must look after them. I speak just personally as to what goes on at the Royal Hobart Hospital, because I have been working there for the past two-and-a-half years. We have about 27 laydown modern beds in the Emergency Department. At any given point in time, about 24 of them on average are taken up by people who need to be admitted.

The average length of stay for a patient who is being admitted is about 11 hours and has gone up. All the important statistics show the trends are worsening. Every year the Australasian College for Emergency Medicine undertakes a nationwide look at the statistics at how hospitals are faring as far as access block is considered and 24 hour stays, for example. The last survey they did, the Royal Hobart Hospital was the worst in the country as far as 24 hour stays. We had 9 patients in the emergency department. They were in the ED for more than 24 hours. Compare that to Victoria who had one patient in an emergency department for 24 hours.

Ms FORREST - Why is this, Bryan? What is the key fundamental problem here or do we not know?

Dr DOYLE - The fundamental problem is capacity. Unfortunately, yes that does take money. That does take inpatient beds. It also takes a lot more. It takes obviously efficiencies with your existing workforce etcetera, but specifically that one thing I mentioned about the 24-hour stays in Victoria only having one. In Victoria they have a policy whereby if you have a patient who is waiting more than 24 hours in the emergency department, it gets reported to the minister. Obviously, there is a strong emphasis on preventing that from the top.

Certainly ASM and Simon could speak to this a bit more has pushed for that to in place in other jurisdictions.

Ms FORREST - I notice in your submission you said you do recommend this. Have you actually recommended that to the Tasmanian Government?

Dr DOYLE - Simon, you can speak to this, but I think you were actually speaking to the minister when you brought this up is that correct?

Dr JUDKINS - Yes, we have spoken to the Health secretary and the Health minister about putting some of these rules and some of these measures in place, not only in Tasmania. Many other jurisdictions are really struggling with similar sorts of issues. One of the suite of measures is having transparent and reportable data around 24-hour stays and really trying to escalate that as a major concern and a zero-tolerance policy while also advocating for mental health patients. It seems odd that we are in a situation where we accept that patients can stay up to 24 hours. I think we need to have a reportable, zero tolerance for 24-hour stays; it really sounds like we are settling for average as opposed to good or excellent.

CHAIR - Some mental health patients are staying for six days, it seems.

Dr JUDKINS - Yes, that is right. It is really such an inhumane thing to do to anybody suffering from not only a mental health problem but any problem, to leave them in a bed in that sort of environment for 24 hours. We would prefer to see a 12-hour zero tolerance for stays in emergency departments. If any of you have been to an emergency department on a Sunday afternoon when there are ambulances ramped out the front, it is a fairly chaotic environment and 12 hours in there is pretty stressful as well. We would like to have seen, across the country, a 12-hour time line come in. As we keep on saying, there is no emergency that lasts more than four hours, but we just don't seem to be able to get there and there are multiple reasons for that.

I mentioned the issue about capacity in the system and that it is not just about the number of beds you have; it is about how we use those beds. The answer to what is happening in the EDs does not lie in the EDs. Although I would advocate that particularly the Royal Hobart Hospital needs more emergency department capacity, I am sure if the team there were asked, 'Do you want a 30 per cent increase in your emergency department beds or do you want a 30 per cent increase in the hospital's capacity to deal with your patients?', they would go for the latter, because it is about getting those patients out of the Emergency Department and into those inpatient beds where they can get the care that they need and deserve.

CHAIR - As long as they can staff the beds, of course, which is always the issue.

Dr JUDKINS - That is an issue. We will come back to it but we need to talk a little about different models of care and the roles of the inpatient teams and BMOs is something I would like to touch on a bit later as well.

Mr FINCH - Bryan and Simon, in the earlier presentation there was a mention of ongoing meetings being held with the minister. We have heard from others before that they don't have that opportunity of that sort of access. I just wonder whether the minister is listening but not hearing what you are saying when from your level, you are presenting the evidence and changes are not being made. You suggest there is a worsening situation in Tasmania, yet your signals at meetings must have been strong.

Dr JUDKINS - I think the situation is worsening and there is a potential that it may worsen before it starts to get better. As was said before, there are a number of ways to solve this problem and they lie within your community resources, to try to keep people well in the community and allow them access to care when they need it, and the default isn't that they come to the emergency department. We see a lot of patients who have multiple chronic diseases and when they deteriorate, they are unable to access a GP in a timely manner or a community service that potentially may negate the need for them to come to hospital, and they subsequently require

inpatient admission. But also, there are methods of increasing capacity within the hospital system to be able to absorb the increasing numbers of patients requiring hospital admission. There are some short-term fixes that can be put in place but really trying to develop capacity that would assist the hospital system takes a whole-system response. There will be some building of extra beds, which takes a long time. The obvious issue is staffing those beds. There is also the conversation about how those beds are used, and this is where we need to look at the inpatients' plans and units, how they are running their units and how they can make a contribution to ensuring there are beds available for their patients. I must emphasise they are the inpatient unit's patients, lying in the Emergency Department's beds.

Dr DOYLE - Getting back to the question asked, nine days ago - last Wednesday - we met with the secretary and also Simon met with the Minister for Health in Launceston. They have been receptive to talk; we had the Health minister at a statewide conference recently and he showed support. Whether that translates into action is the major question or concern.

Simon, you met with the minister on Wednesday, did you want to provide feedback on that?

Dr JUDKINS - From my conversations with the minister, I think he gets it; I think he understands this is a crisis. But it is a crisis that has taken many years of lack of investment into infrastructure and system change to get to the point where it is as bad as it is. He understands that. I think he understands that investment into beds needs to happen. I think he understands there is investment into staff. He has made a commitment to work with the Australasian College for Emergency Medicine to look at a long-term strategy for staffing emergency departments in Tasmania. That will help a little as far as making sure we have the right number of senior decision-makers within the emergency departments, but it still won't solve the ongoing problem of the hospital capacity, which I think the minister also recognises is the key to all of this - getting the patients through the system and doing it efficiently. I think he understands the challenges. I think he understands where some of the solutions are.

The thing we are having trouble with is engaging with the other clinical leaders within the hospitals to understand their role and help them provide solutions.

CHAIR - Will that include proper consultation with the people at the coalface, the nurses et cetera?

Dr JUDKINS - I can't speak on the meetings they might have had with the nursing staff, but I understand, looking from the outside at some of the meetings, that there has been a high level of hostility, particularly around the current situation in Launceston. It is worth understanding that everybody knows this is a very bad situation. It is also worth everybody understanding that in order to get out this situation, people need to be on board with a common understanding of what the solutions are.

CHAIR - A holistic solution.

Dr JUDKINS - It has to be everybody from within the emergency departments, but everybody working within the hospital system has to realise that they have a contribution to make in sorting this problem out. You can build as many beds as you want and it costs money, but if you have patients and you do not have systems to use those beds effectively and efficiently, it is almost like you are building a bigger car park. It won't work.

Ms FORREST - This is an area I raised with the ANMF when they were here. We have seen significant change over time in the way the DEMs are run, in that we now have emergency medicine specialists. When I was a young thing working there, we did not have those, we just had residents running the show. That has made a huge difference to how the DEMs are run. We have seen standalone day surgery units established in a lot of places, not so much in Tasmania to any great degree yet, but that could be part of the solution. On the medical side of it, as I understand it, a lot of the patients in the medical wards are waiting for something and perhaps exacerbating the bed block for medical patients. From the DEM's point of view, when you have so many patients waiting for beds, are they waiting predominantly for surgical beds or medical beds? I know there would be some mental health beds, and we have covered that to a large degree so I will put that aside for now. Is there a predominance of medical patients and if there is, how do we streamline these processes so that beds becomes available? As you say, you can build as many beds as you like. It is the efficiency of the beds and the use of the beds that matters as much as anything.

Dr DOYLE - I can answer the question about what type of beds are the major issue. Yes, it is primarily medical but, following on, the proportion of surgical beds, and mental health - even though it makes up a small proportion - patients spend a long time in the emergency department. As far as systems to maximise efficiency are concerned, it sounded like Simon wanted to jump in so I will let Simon answer that.

Dr JUDKINS - There are a couple of points you raised there. A lot of places have, for example, separated elective surgery from emergency surgery. You have a cohort in your elective surgical centre. I can give you an example of the place where I work in Melbourne. We have an elective surgical centre that runs separately to the main hospital. You do not have to necessarily be cancelling elective surgery to cater to your emergency loads. You can continue. That takes some investment.

We haven't really changed the model of care, of how we run our inpatient units, for a long time. When you think about how you get a patient through the system, it is about having people with the capacity to make decisions in a timely manner available to make those decisions. We still run on a system that has the most junior staff doing most of the work and waiting for their bosses to come in and make decisions.

Ms FORREST - Could that be improved, Simon, by having specialist physicians that oversee the medical wards and are there all the time, like you have emergency medicine doctors in the DEMs?

Dr JUDKINS - If you look at what happens in the DEM, the decision to admit a patient almost, in many cases, happens as soon as the patient comes through the door because we know that patient needs to be admitted. Somebody comes in who has had a fall and have a hip fracture. That can be identified at the front door and their admission facilitated. Seeing the decision-makers does have significant impact. Having a system where you are reliant on a VMO model, a Visiting Medical Officer-model of specialist care, in which they might only do ward round in the afternoon - I am not really familiar with how they structure the inpatient teams - or in some cases some units might only be doing rounds with their specialists every second or third day, you are not going to get to move more patients through the system.

One of things we really need to ask is: do we need to move away from an inpatient specialist system that relies on VMOs to a system where we have more full-time specialists, or at least

specialists with substantive commitment to the hospital, to really invest in effective and efficient care of patients? If we only have senior decision-makers in the place for a couple of hours every now and then, you can see why patients are sitting and waiting.

A couple of years ago there was a review of the Royal Hobart Hospital by Kate Brockman. She identified - and it is not unique to the Royal Hobart Hospital, she has done this in many hospitals - what is called the latent capacity in the system. At any time, we could wander down to the hospital now - I can't because I am not in Tasmania - but you would identify patients who are sitting in acute hospital beds who are waiting to go to their rehabilitation bed, their substitute bed or waiting to go home.

CHAIR - We heard that evidence earlier in the nursing submission that there were people waiting and it was causing bed block because they simply didn't have someone to sign them off to go home.

Ms FORREST - In your submission it says that ACEM recommends employing permanent salaried staff to better address gaps and staffing numbers rather than relying on the VMOs, as you are saying. Has this been raised with the minister?

Dr JUDKIN - Yes, it has.

Ms FORREST - What was the response?

Dr JUDKINS - Mr Ferguson understands this is something that needs to be looked at but I would have to emphasise this is also a conversation we have had in South Australia. We have had this conversation in a number of different jurisdictions. The challenge is getting the right people to do that. That is really a culture change and it is a significant change in the way we run the inpatient services in our public hospitals. We haven't really looked at changing that model of care in the Australian public hospital system for the last 30 or 40 years. This is the time we really need to change that. It improves patient flow and it is going to have a significant impact on patient care, misdiagnosis; all sorts of benefits.

Having an invested cohort of senior clinicians in the inpatients will result in better outcomes for patients. It is hard to argue against it. It is really a matter of getting an opinion from the other specialty colleges about how they view that suggestion. From where we see it, it does seem like it is one of a suite of suggestions that could have significant impact. We really need to have a serious conversation about how we might do that.

CHAIR - Before I throw to Kerry, you are suggesting that perhaps somebody who does something like a time and motion study should be brought into the reorganisation of things?

Dr JUDKINS - There is probably evidence already out there to show that going on a VMO type model does impact patient care. You can look at the targeting zero work that Stephen Duckett did in Victoria, talking about the difference between VMO models and full-time hospital specialists. There is probably enough evidence out there to say we need to change the way we engage with the other specialists.

CHAIR - Thank you for that.

Mr FINCH - Simon, in your recent discussions with the minister, did you touch on ministerial notification of access block exceeding 24 hours? If so, what was his response to that?

Dr JUDKINS - We raised that as an issue. The meeting was only last week. It is something the minister is looking at. If you look at the current situation in Tasmania, we know the number of 24-hour stays is enormous. It almost becomes something that is probably not as effective. The system is so far past the need to report on 24-hour stays, if you know what I mean, it almost becomes an -

Ms FORREST - He would be getting a text message every five minutes.

Dr JUDKINS - When it was introduced in Victoria, it was becoming more of a problem so we wanted to try to ration it back to where we were historically. I think you are so far past that, you need to do a lot of work in the system to get to a point it is manageable. Then you introduce those alerts, such as I want to know every time the system fails. I think reporting them on a daily basis almost becomes pointless because you know it is happening anyway. I think you need to address the problem first and then maintain it at that level of performance.

Mr FINCH - You suggest that has been effective in Victoria. Would that signal going to the minister prove to be as effective here?

Dr JUDKINS - The minister would need to sit down with the CEOs, the directors of the hospital, and say, let's start working on reducing the number of 24-hour stays. Once we have plan in place to fix it, we will put the reporting lines in place. If it started now, it becomes ineffective. You need to put the plans in place as to how you are going to address the 24-hour stays. Now, put the rule in place but you also want a report because you want to see reports on how it is improving. There needs to be agreement. We need to get a plan on how we get that 24-hour number down to zero and then we start the reporting so we know there is progress being made.

CHAIR - I don't know whether danger is the right word, but is this reporting to the minister is injecting a bit of politics into the situation and might that have a downside depending on what the minister does with the information he receives.

Dr JUDKINS - Working in the public health system and reporting on performance indicators, one of the things is they can be used as political footballs. We find this incredibly frustrating that they are not used as bipartisan agreement we need to address these issues and make them better. Like anything in politics, if it was understood there was a common goal where everybody involved advocated for the healthcare system and seeing an improvement, we would be much happier. There is always a danger it gets used as a whipping tool and more headlines. There have been lots of headlines and it is time to actually say, 'Let us try to work together to find some good solutions'.

CHAIR - Thank you.

Ms FORREST - Going back to the discussion about the VMO model currently in place - and you would know much better than me about this - in some parts of the United States there is a term, 'hospitallers'. All doctors like to have specialist titles, and Bryan is smiling across the table. Are you aware of that model and how could this apply in something like this? Is that what we were talking about in terms of having a senior clinician responsible for the medical hospital

inpatients, whether they are in the emergency department, medical ward or wherever they may be, and addressing those patient flow issues?

Dr JUDKINS - I suppose, what do you call it - hospitallers. What we actually advocating is to have the specialist physicians in the hospital for more hours than currently. An example, again, is the hospital where I worked a number of years ago. The hospital decided to employ a full-time director of orthopaedic surgery and our infection rate in the orthopaedic unit went to zero very quickly. They became more effective, more efficient, and patients were discharged from hospital sooner because they had a team-based approach on how they were going to manage fractured hips, for example - it was not up to individuals. As soon as you actually reduce the variations of care and it is not based on individual surgeons' preferences, but based on what the surgeons agree is going to be a common pathway for patients, we see a decrease in medical error and decreasing risk.

Having somebody who is responsible for the running of the unit on a day-to-day basis, whether that is one person, two, or three, having as part of their role to improve consistency of care, improve patient outcomes, improves patient flow. For VMO models, that is not necessarily wrapped up as part of their job.

Ms FORREST - I have sat on a number of health committees and hear the iterations of this through time, but the challenge is particularly with surgeons who like to do things their way. They will not use the particular prosthesis or they want to use this particular method and they do not want any other specialists telling them how to do it. Is this still a problem? Have we seen this work somewhere? You have described one with the hospital you worked at in the orthopaedic section; can that work in the medical or physicians' role? Can it work in other areas?

Dr JUDKINS - There is always going to be that variation. There are obviously evidence-based approaches to a lot of things we do and different treatments. Bryan will also support that in an emergency department you have different clinicians who manage particular conditions. We might all reduce a dislocated shoulder, but might use different medication for our procedure or sedation but, ultimately, all the clinicians working in an emergency department have a common goal and that is to see patients as effectively and efficiently as they can and get them through the system in a timely manner to where they can get their care.

By having a director who is available and not off to meetings about patient flow and is available to look at the quality and audit type things. Having similar sorts of roles, we are not asking everybody to do the same thing and do not think you would ever get to that point - but having common pathways monitored. Having engaged with people when things do not go right, having engaged with people when there is access block on a weekend and there are patients who can be discharged and the role and responsibility of some senior people who provide that support and get people moving through the system, can only improve the system.

CHAIR - What level of concern do you have for your members working in the current environment?

Dr DOYLE - I can obviously give the Tasmanian perspective. I cannot give you a statistic about wellbeing of the emergency department doctors, but the sense is it is at all-time low, certainly at the Royal Hobart Emergency Department. There is usually quite a lot of excitement about trainees wanting to continue and pursue a career in emergency medicine and we have started to see that turn and go the other direction. Doctors and registrars come up to me and

rethink their career choice because they see how bad things are and think, 'Oh gosh, I do not want to work like this, this is awful.' Patients spending days in the emergency department, taking care of patients in corridors with no privacy and knowing how to look after a patient effectively and efficiently but you cannot. It is really frustrating, awful and horrible.

Certainly recruitment for our registrar positions, which I was involved with - last year we were turning people away, this year we are begging people to come. That is at a tertiary centre at the Royal Hobart Hospital and traditionally not a problem. Usually people want to work here and we get some of the best candidates. Now, honestly, we are inviting basically anybody who seems qualified to come.

CHAIR - How many years of experience have you had down there?

Dr DOYLE - I have been at the Royal Hobart for two-and-a-half years, but in Tasmania for 12. In Burnie, we always had challenges with recruitment, because it is a smaller peripheral hospital, but never has it been the case at the tertiary centre. When I was in the north-west, we always would get the spillings of those they did not recruit.

CHAIR - Over that period of time of your experience, have you seen doctors go through specific stress to the point where colleagues may be concerned about them and how is it being dealt with?

Dr DOYLE - Absolutely. There are definitely issues with burnout. You become an emergency specialist - honestly, I did - because you really enjoy the work and you almost get excited about coming in.

CHAIR - It is challenging, if nothing else.

Dr DOYLE - Absolutely. You were excited about going in for a shift. Certainly now in particular the evening shift in the emergency department where everything is backed up and once again you are really just doing the best you can to look after people who are in the wrong place, it is frustrating. It is demoralising and depressing at times. I have had staff whom I have counselled myself who have had issues with burnout. We all talk about resilience training. Within our own department we have done the best we can to try to improve morale with organising activities, journal clubs, dinners and retreats, but there is only so much you can do.

CHAIR - As a college, is there any issue around the mandatory reporting situation that occurs where somebody recognises a colleague is not doing too well and not behaving in the way expected of the position?

Dr DOYLE - Simon?

CHAIR - I am thinking of patient safety obviously, but also the person involved.

Dr JUDKINS - It is a problem because there are concerns about mandatory reporting. We need to do a lot more about recognising issues of stress and burnout and being supportive of colleagues. Much of the work the college is doing is happening at the coalface, putting in peer support networks, investing in clinician wellbeing, trying to ensure there are adequate resources around debriefing of critical incidents. Trying to address those issues at the coalface and support people through. We all recognise working in emergency medicine, that at some point in time we

do not want to turn up to work and it is happening to everybody. You just get up in the morning and go, 'After last night, there is no way I want to back to that place because it was so stressful'.

It doesn't make sense that the hospital system would invest all that time and resources in employing people and getting them through training and then putting them into an environment that we know is going to cause them stress and makes them burn out in a few years' time. We know the sustainability of the workforce is a real problem because doing the frontline clinical work, shift work and all that weekend work does become incredibly draining.

CHAIR - The issue is that with that mandatory reporting in place, the concern is that doctors may not wish to refer themselves to help simply because of the impact it is likely to have on them, and you might therefore have a doctor who is even more compromised and not able to do the job.

Dr JUDKINS - You are right - we need to be much better at putting systems in place instead of having the mandatory reporting. We have to make sure that there are systems in place so people recognise that they can be supported and it is not a black mark on a doctor.

CHAIR - It is not a personal failure.

Dr JUDKINS - That is right. Unfortunately, we have this idea - moving into misdiagnosis, which is something I wanted to discuss with you - this expectation that we are never going to miss a diagnosis or never going to make an error. Everybody in their life makes a misjudgment or a medical error, but for some reason there is a different light that seems to be shone upon clinicians. We are concerned because as we see more and more pressure coming down on the emergency departments. With increasing presentations, increasing expectations and time-based indicators, we know we are going to misdiagnose something - and you do not know when it is going to happen. We are putting people in an environment where they are taking risks and they are working in an environment that has risks built into their work. It is incredibly stressful for people to work in that environment, knowing that at some point in time they will have to make one of hundreds of decisions they will make in their daily work, and one of them might be wrong and that might impact a patient's outcome. That is incredibly stressful.

CHAIR - Would you see that taking that mandatory reporting out of legislation might be a positive way forward?

Dr JUDKINS - That is a big debate at the moment. It is something that needs to be considered. From an emergency department perspective, we need to recognise that if we work in that environment we constantly need to provide people with support and make sure they recognise it is okay to be stressed and they need to deal with it - it is okay to feel burnt out but they need to deal with that.

We need to accept that at some time people need to have a bit of time away from work so they can regroup. This is why we advocate strongly for clinicians to have some clinical support time or time out of the clinical environment to do other projects that will add to the quality of the service the emergency department can deliver. That is still an ongoing battle we have with many health services.

Ms FORREST - You need redundancy in the system to the achieve that, surely. Having worked in the system, you get called in for an extra shift or whatever, particularly in the flu season, which we have not really had this year, thankfully. We can only imagine how bad it could

have been. When those kinds of things happen, you have this situation where you are on the end of the phone and the last place you want to be is back in the unit, but you know what it is like to be there without people, so you go.

Dr JUDKINS - There is not a lot of slack in the system for holidays [inaudible]. I know that at the moment with Launceston and the Royal Hobart, they are working well below what we, as a college, would consider to be appropriate staffing levels. When there are sick calls - we also recognise people just take days off work because their colleagues feel like they need to come back in and support their work colleagues because they know how bad that can be - you are exactly right, that is a vicious cycle just leading to more and more burnout.

CHAIR - Simon, you said that you wanted to mention something else in relation to inpatient care. Was it about misdiagnoses?

Dr JUDKINS - We were just talking about the issues around misdiagnosis. It was interesting, we were having a conversation in a meeting with the VMIA - Victorian Medical Insurance Agency - recently. We are now seeing that the number of complaints about misdiagnoses and mental health care coming out of emergency departments across Australia has now become the highest number of claims.

I think this is a manifestation of the environment that we are working in, that there is so much risk that is being cohorted in the ED. The increase in demands against the dwindling supply means we are creating an environment that is going to lead to misdiagnoses and medical errors, and we know that is an enormous cost to the healthcare system.

One of the questions asked last time we spoke was: what is the cost of this access block and overcrowding on the healthcare system? If we look at the increase in misdiagnoses and errors, which, in the emergency department is significantly impacted on by this system that we work in, that is costing billions of dollars in the Australian healthcare system every year.

If we could put strategies in place to actually decrease the risk and have the right level of senior decision-makers, consultant support, access to proper diagnostics and good patient flow, we would bring that cost to the healthcare system down significantly.

Mr FINCH - Simon and Bryan, in your submission you highlighted the $1.5 million that was provided by the Tasmanian Government for the emergency departments at the Royal and at the LGH. Also in that, you touched upon the withdrawing of training accreditation at the LGH in March 2018. Can you apprise the committee of the circumstances now for the Royal Hobart Hospital and also the status of the LGH of the training accreditation?

Dr DOYLE - Simon, I will touch on that, at least on the latter point. Regarding the accreditation at the Launceston General Hospital, it has been a long-term - I hate to use the phrase - scraping by of accreditation for many years.

Unfortunately, they really lost a number of their senior staff. I spoke to the director of the emergency medicine, Dr Lucy Reed, at the Launceston General Hospital yesterday. She thinks it is probably about a year off, give or take, getting the accreditation back. It is multifactorial. It is not just senior emergency doctors; it is going to be a whole bunch of systems in place as far as supervision of junior doctors and helping out with their exams and a number of other things. I think realistically that is about it.

Getting back to the $1.5 million, I will be honest with you: it is a welcome step in the right direction. It is a fixed-term amount of money and it is not intended to be ongoing. It looks at some important things that will improve flow to a certain extent.

Honestly, much more needs to be done and I think a lot of people recognise that. I think just about everybody recognises there is a significant problem. That has been highlighted. I don't think we need to debate that one bit, and the problem is actually getting worse.

The challenging and frustrating thing for clinicians is that the solutions are not novel. We know what the solutions are. It is improving capacity and improving efficiency. That can happen, but it has to be matched not just with lip service but with real action. Some of that will require money, yes, and that is obviously challenging, and ensuring there is capacity.

The last thing I will say is that certainly when I was the director of emergency medicine in the North West Regional Hospital for many years, I recognised the best way to ensure that patients were being looked after in the emergency department was to ensure we had as much time of a senior clinician decision-maker in the ED as much as possible, somebody who knows what they are doing, looking after the patients as much as possible. That is the best thing. I ensured we did that and that improved the flow because a doctor who has been around for 20 years can take a look at one person and say, 'No, you are fine, you can go home', as opposed to a junior doctor who might order a whole bunch of tests and he will be there for hours or he might admit the patient inappropriately. Down in Hobart it is a little bit challenging. We don't have the emergency specialist establishment to staff the emergency department adequately. The frustrating thing is, if somebody said, 'Okay, you can have three extra FACEMs on your books', we could employ them tomorrow. We have a solution but we do not have the means to enact it, that is the challenging thing.

Ms FORREST - So 'the means' being money in this case or is there more than that?

Dr DOYLE - Yes, personnel, they are expensive.

Ms FORREST - We don't have these people trained at the moment, is that what you are saying?

Dr DOYLE - Yes, they are there and people would take the positions tomorrow if we had the funding for the positions. It is different in Launceston, where there is vacant establishment, and certainly in the north-west. I think things could flow better in the Emergency Department at the Royal Hobart Hospital if we had more senior staff on our books who could make those cost-effective decisions really quickly and get people in and out - senior clinicians, decisions-makers - as much as possible.

Ms FORREST - That flows through the whole hospital -

Dr DOYLE - Yes. You get a couple of patients admitted by registrars who probably could have been managed in the community and that is called beds that are blocked. I know when I am working, I put a big emphasis on actively managing patient flow. We will often have three doctors on the morning shift, one of whom has to look after our short stay unit, and then we have fewer doctors around at times where our volume goes up. That is rather frustrating and it would be nice to have the resources to manage things appropriately.

Ms FORREST - In that case, Bryan, do you think more patients would be sent home?

Dr DOYLE - I think a senior clinical decision-maker who has been around for a long time is more likely to make a clinical diagnosis without resorting to a lot of tests. Depending how risk-averse they are, some may admit more and some fewer, but you find the more junior-level doctors are less likely to make a clinical decision. They are a bit more cautious, which is fair enough because they are junior. They don't want to make a critical mistake but somebody who has been around for a while is more confident in their capabilities and abilities and that their decisions are going to be correct.

Ms FORREST - They have seen more.

Dr DOYLE - Exactly, yes.

Dr JUDKINS - That is a very good point and I would wholeheartedly agree. One of the things we can do ensure we are minimising risks for patients is having people who are experienced at the coalface as much of the day and of the week as we can. I don't think we can move away from that. We have to recognise that is a part of the solution. It is still not getting the mental health patient out of the emergency department under five days.

We have to ensure we invest in proper senior staff and FACEMs who can multi-task, who can absorb risk and who can make those decisions. I emphasise we can invest in the emergency physicians but if we keep on putting them back in that environment - where they are seeing the same patients in their ED over and over again and they are not able to work at the top of their scope of practice or practice good emergency medicine because of the environment they are in, it does become increasingly stressful. It doesn't solve the problem of getting Mrs Jones, with her fractured hip, up onto the orthopaedic ward in less than a day. We will need to make sure that there is that investment in the access block stuff as well.

Mr FINCH - Something else mentioned in the submission was patient flow partnership, the program in Victoria. Could you tell the committee, Simon or Bryan, about what initiatives contained in that program might translate to Tasmania?

Dr JUDKINS - I am trying to find that in the submission.

CHAIR - Page 3, at the bottom of the page.

Dr DOYLE - I forget the terminology, Simon, it was 'better stays Victoria'.

Dr JUDKINS - Better Care Victoria. There are a number of different initiatives that have taken place in Victoria and a lot of it arose from recommendations made when we had some system failures and patient errors. One of them was Better Care Victoria, there was Safer Carer Victoria and there was the Victorian Clinical Council, all of which are collaborative organisations or structures to bring clinicians from inpatient areas - prisons, communities, clinicians from the emergency departments - to work out how we can improve patient flow through the hospital system. It is not purely based on emergency departments. We focus on how we can use our public hospital systems effectively and efficiently.

I suppose the take-home points, if you need to reflect on what happens locally, I am sure the directors of both emergency departments would emphasise this. For example, when the hospitals have their patient flow and access meetings, normally you would find the only people who turn up to those meetings are the emergency clinicians. What we need to do to ensure we get better care and better protective systems is to engage the rest of the system in finding solutions. What some of these structures have done is broken down some of the silos between different clerk groups and different specialties to provide the common solution in our common goal, which is better patient care. It allows that collaborative work on solutions and that is something that can be looked at in Tasmania; to develop something like a critical council, which brings in your physicians, your surgeons, your paediatricians and your mental health clinicians all in one room with the minister or with the medical secretary, whoever that may be, to look at the hotspots in the Tasmanian healthcare system. They can work out how they can collaborate together to find some effective solutions.

CHAIR - I am aware we are running over time. You may have things you have to get to. Are you able to take one more question?

Dr JUDKINS - Yes.

CHAIR - Under other issues for this committee's consideration, you talk about the relief of the gun control legislation inquiry. The Legislative Council conducted one and the Government began backing away from making changes. Are you aware that the lower House had an inquiry into gun control? You might wish to submit to them?

Dr JUDKINS - We were aware that this issue was being reassessed. From an emergency medicine perspective, the last thing we want to see are patients turning up to our EDs with injuries due to guns. I have seen this overseas in the United States, which is obvious. This is part of prevention of injury, accident and health. We are aware and if we can make another submission, we will.

CHAIR - It is a lower House inquiry. There was an upper House inquiry but that ceased when the Government changed the terms of reference with the action they took. There is a lower House inquiry; as long as you are aware of that. We appreciate the effort you have taken to brief us again. Thank you for your time. To reiterate, anything you have said today is covered by parliamentary privilege but it may not be if you walk out the door and talk to the media.

Dr JUDKINS - Thank you so much for inviting us and listening, we are happy help in any way we can.

CHAIR - It is always good to get information from the grassroots. Thank you.

THE WITNESSES WITHDREW.