PUBLIC

THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN THE LEGISLATIVE COUNCIL MEETING ROOM, HENTY HOUSE, LAUNCESTON, ON WEDNESDAY 8 NOVEMBER 2023

STELLA JENNINGS WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Dr Woodruff) - Before you begin giving your evidence, I want to ask whether you have received and read the guide that the Committee sent?

Ms JENNINGS - Yes, I did.

CHAIR - A committee hearing is a proceeding of parliament and it means that it gets the protection of parliamentary privilege. It is an important legal protection that allows you to give evidence to the parliamentary committee to speak with complete freedom, without the fear of being sued or questioned in any court or place out of parliament.

It applies to ensure the parliament gets the best information when we are conducting our inquiries. It is important to know that the protection is not given to you if you make statements that could be defamatory or repeated or referred to outside of the confines of this proceedings.

This is a public hearing, so there are journalists here and other members of the public who might be present. That means that your evidence can be reported.

It is important if you want all or part of your evidence to be heard in private, that you can let us know and we can go in camera if you decide that is what you want or need to do to give some extra information.

Do you understand all of that?

Ms JENNINGS - Yes, I do.

CHAIR - Is there a statement that you would like to make? We have all read your submission deeply and I want to say that we are here if you want to take a break at any time. Would you like to make a statement before we start?

Ms JENNINGS - Yes, I would, that'd be great, thank you for the opportunity. I would really to thank you all for letting me speak today, it's something that I really wish that I didn't have to do, no one wants to be here. It has been 15 months now since my mum passed away at Launceston General Hospital, after she spent over eight hours with ambulance services in the Emergency Department and she was never admitted as a patient. She was ramped that entire time.

There is nothing that we can do to make mum come back to us, but I know my mum, she always looked out for other people and she always encouraged me to do the same. I think that she would want her death to be, at the least, a catalyst for some change so that other families don't have go through what we've been through.

I know that you have my submission, thank you, so I won't go over the details of that and what happened that night. I would like to speak about what has been done since, or perhaps what hasn't been done since, as the case may be.

Subsequent to my mum's death, my husband and I attended a meeting with the CEO of the Launceston General Hospital at the time, the CEO of Ambulance Tasmania and the assistant medical director of the hospital.

They used very sympathetic language and went through their root cause analysis that they'd prepared with us quite thoroughly. They didn't make a lot of those really critical issues transparent to us. It really wasn't until the Coroner's report came down some months later, that we really began to understand the breadth of some the issues and the severity of the issues and failures that ultimately led to my mum's death.

The Launceston Hospital root cause analysis acknowledged that the wait time was too long. It primarily pinned the issue to a missed follow-up phone call to check on pathology results. They assiduously assured us that this was now updated in their staff training, and it wouldn't happen again. They seemed to feel that that was completely sufficient, and the matter was adequately addressed.

Even after that meeting that Joe and I attended - and that was only three months after mum had passed away and we were still in shock because it had been so unexpected - even then we were a little baffled and felt that that it couldn't be an accurate reflection of everything that had happened. It was too simple.

Months later the Coroner's report was published and we were invited to a further meeting with the new Health Minister, Mr Barnett, and the new CEO of the hospital, Ms Lieutier, and the head of the emergency department. There it was acknowledged, in fairness, that there were broad systemic issues, and that the matter of a single phone call was only a minor part of that.

This committee had already been announced at that time, and we welcomed that news then, as we do now. We didn't discuss the ramping as much within that meeting because we realised that it would be part of this piece of work that you're all doing today.

We did discuss in detail the fact that it had come to light through the Coroner's report, that the Launceston General Hospital has no 24-hour pathology or radiology department. They have an on-call service only. In a hospital as large as the Launceston General Hospital, servicing an area as wide and as broad as they do, how is it that possible? Do people understand this? We certainly just assumed, as people not in the medical field probably do, that that is a standard thing you would have. It was absolutely amazing to us.

It was agreed at that meeting that they would look into the reasons behind why there wasn't those services available. The minister agreed at that time that it probably wouldn't be a budgetary issue. I have been quite forthright because at that stage the almost billion-dollar sports stadium had just been announced, and I was forthright in saying I didn't think that the public - and certainly not our family - would like to hear about budgetary restrictions being the barrier there. He agreed with that.

There was mention that it would be difficult to find qualified staff in the area, but when we queried if the positions had ever actually been advertised, they hadn't. Again, I am not a

medical professional but it seems to me that you can't say that someone's not available or can't be sourced if you haven't asked the question or advertised the position.

At that stage the minister said he would arrange an update for me in the coming weeks and months, probably more like weeks. That brings me to last week and I realised I hadn't had that update so I took it upon myself to contact the minister again, who again was quite happy to take my call, arranged for Ms Lieutier to call me back - which she promptly did, in fairness - to give me an update on what's been happening in this space since.

Ms Lieutier advised that as a direct result of my mum's passing they have increased the consultant numbers in the emergency department from two to three. I welcomed that and thanked her for that update. It was very positive news.

However, there's been no progress made in terms of 24-hour pathology or radiology. Ms Lieutier advised that the radiology budget for 24-hour staffing has been submitted, but there's no time frame for when she'll get an answer on that, and that's been in for however long, it's not moving. There has been no request for 24-hour pathology because she advised that they were waiting on a state-wide review to be finalised. I am not sure if that's this or something else entirely.

Basically, three months has passed since our meeting and yet we still seem to be in exactly the same place that we were before we ever went to the meeting. We are still in the same place that we were 15 months ago when my mum passed away because they didn't have the staff on site.

Ms Lieutier also mentioned that it is quite normal not to have 24-hour radiology and pathology on site at a hospital and that the Royal Hobart Hospital also doesn't have this. I think she meant that to be, in fairness, comforting to me - like, "it's okay because the Royal Hobart Hospital doesn't either," but, to be honest, that was even more horrifying to me. I said, "that's not okay." It is not okay at the Launceston hospital, it doesn't make it better to me that the Royal Hobart Hospital also doesn't have those services. I am not sure what the point was there.

She mentioned again that the lack of qualified staff is going to be barrier. Again, I asked if any advertisements had been placed, and none have. I don't understand how you can make a statement as to what staffing is available if you haven't advertised. Ms Lieutier also advised that the current on-call system allowed for radiology staff to be back in the hospital within 15 minutes of being called. Bless the radiographers, they must be Herculean to be able to woken up in the middle of the night, get dressed, get to their car, get to the hospital, park and run to their offices at the speed of light, presumably, to get there within 15 minutes.

Even if they have been able to do that, surely it is not an efficient use of their time if you are doing that multiple times a night. I don't understand how that makes any sense whatsoever. It must be awfully fatiguing for staff, which will lead to further errors. It logically has to contribute to delays in moving patients from emergency to either a ward or to discharge, or wherever their pathway is about to take them.

I am not in the medical field, as I said, and I know that many people are working towards trying to make these systems better and give people better outcomes than we've had, but the pace of this change is so incredibly slow that it appears to not be moving at all. I understand that there are big pieces of work to be done and that is what you are here to do, and I appreciate

that and I thank you for it. It is not clear to me why some small changes cannot be made in the interim period. No one's been able to explain that to me or my family. It has been 15 months and the coroner made it very clear in his report that failure to put any change in place will lead to more fatalities. Not if or maybe, it will. I am trying, as best I can, as someone who is not in the field and who's not part of this system, to effect some change that will help other families. I really appreciate all of your support in also trying to reach those outcomes. Thank you.

CHAIR - Thank you so much for providing that. It is really important to understand the small as well as the big. We are looking at the things that could be done now as well as the long-term issues. One of the other things that you didn't mention about your meeting with the minister was that the Coroner's report noticed that there were critical information gaps in your mum's medical records. That has obviously led to incorrect work being done and later staff not having information they ought to have had. Did you talk to the minister or any other people in the LGH and the medical director about that? What was the conversation?

Ms JENNINGS - The conversation was that because we had previously moved from Melbourne, the history had not come, there is no national database or whatever you would like to call it, so they had limited history for my mum. When we went to the initial meeting at the Launceston hospital, we did question why they didn't ask my mother. She was conscious. She only crashed at the very end. She was conscious, she was a very bright lady, she was well able to advocate for herself and speak for herself. They only needed to ask the questions and she would have been able to tell them. It wasn't clear to us why that hadn't happened. In the worst-case scenario, they could have contacted my father or myself as next of kin to ask those questions, but they weren't asked.

CHAIR - The Coroner also, as I read it, seemed to be talking about critical information that was missing from the medical records. I think there's two things happening here. I think it's about the records that were or weren't taken at the time in the hospital, such as procedural and medical notes particularly related to decision making about what was happening for your mum. Was there any discussion with her?

Ms JENNINGS - No. That was the frustrating thing we found coming away from that, particularly that initial meeting at the hospital, that we felt that a lot of that detail was glossed over and they really wanted to stick to just explaining their root cause analysis. Because we didn't understand as much then as we do now because we did not have the Coroner's report, we didn't understand some of those issues. Even if we'd had the presence of mind to call them out, in a sense, because we were only three months away from my mother's death and we hadn't even processed it. We just could not get our heads around it. It was more like we were hoping they would tell us what was wrong, but they just told us the parts that they wished to tell us, or perhaps they didn't know more than that, I don't know, but it certainly wasn't an informative meeting.

CHAIR - Were you given a copy of the root cause analysis that they did? Do you have any comments about that?

Ms JENNINGS - We felt that it was biased. They announced that they were going to do one, they said it would be independently looked at, and I don't think that either myself or my husband felt that it was really independent. It felt very much like an internal document to the hospital that was there to perhaps put the best light on the hospital and not look at the actual issues.

CHAIR - Is that something you would be prepared to table for the committee?

Ms JENNINGS - Yes.

CHAIR - For us to have on our records.

Ms JENNINGS - Yes.

CHAIR - Okay. Do I need to move that, if everyone would be comfortable with that? You didn't get a sense that they had even gone into the detail of the issues that the Coroner reported to?

Ms JENNINGS - No, when you look at the root cause analysis and then you look at the Coroner's report, they're two different documents entirely. Yes, there is some overlap, but mostly what the Coroner is saying is not in line with what the RCA said.

CHAIR - There also wasn't an experienced cardiologist and work was done by a registrar, and that was against the practice guidelines of the hospital. That is what the Coroner found?

Ms JENNINGS - Yes.

CHAIR - Did they have any comments about the availability of the cardiologist?

Ms JENNINGS - No, that's not something we discussed.

CHAIR - You mentioned earlier when I spoke to you that where you've come from a 24-hour pathology and radiology is something you have taken for granted, and you didn't realise coming to Tasmania that wouldn't be the case?

Ms JENNINGS - No.

CHAIR - You also mention in your submission that you believe Mersey Hospital does have 24-hour onsite services?

Ms JENNINGS - I believe so. A friend of ours is a nurse who has a friend who is also a nurse who does that service. I believe that would be true.

CHAIR - What staffing was the minister talking about adding on that he was going to advertise for?

Ms JENNINGS - That was the 24-hour, the people to deal with the overnight pathology and radiology. That was what my husband and I focused on in that meeting because we felt that that was the smaller change that perhaps we could help to work towards. Obviously, we understand that the broader picture of this and the systemic issues within the hospital and flow of patients is a really big piece of work, more than we are able to tackle. As for the smaller issues, we felt that perhaps we could advocate for some change. We did focus mostly on those two things. Those were the staff we were discussing.

CHAIR - While your mum was on the ramp, did you have any ability to contact her?

Ms JENNINGS - No, because my mother and father live separately to us. They told dad not to come because of the COVID-19 issue and they were not encouraging additional people. Dad stayed at home and I didn't even know that she'd gone to hospital. It was in the middle of the night and my father didn't call me. We didn't know anything until the next morning when they called from the hospital and she'd already passed.

CHAIR - You don't have any information about whether there was nursing available to her on the ramp, or whether it was just paramedics who were with her at the time?

Ms JENNINGS - The hospital said that there were doctors who saw her, even though she hadn't been admitted, but they were fairly vague on the details. I'm not 100 per cent certain how much care she was given or by whom. At the initial meeting at the hospital they kept talking about a dual-care mode. That rang alarm bells in our heads a little bit. They tried to paint the idea that someone was ramped under a dual-care mode where they were both looked after by the ambulance officer and also hospital staff. Again, even as laypeople, we wondered how on Earth that can be efficient or the best possible practice? They were trying to portray that she was fine because she had not only the ambulance, but also doctors and nurses looking in on her. Obviously, it's not right and it's not optimum care at all. In fact, the Coroner went on to talk about the substandard care that she was given.

CHAIR - Yes. Michelle, did you have a question?

Ms O'BYRNE - I just had a couple of questions. I have gone through one of those ramping-in-the-hospital experiences recently, so I understand how distressing and frightening this has been. In your meetings with the hospital, were they clear to you where, physically, your mum was during this time? The layout of the hospital is that there are some beds that she may have been transferred to that are monitored by the paramedic staff, or even before admission she might be in a cubicle but not admitted, or she may be in a corridor. Do you have any idea about where your mum was? That would impact on some of those questions you have about that dual-care arrangement.

Ms JENNINGS - They did talk about it at that first meeting and I am trying to remember.

Ms O'BYRNE - Is it too hard? Yes. No, that's fine.

Ms JENNINGS - The CEO of Ambulance Tasmania made it clear that she was not ramped in an ambulance. She was inside.

Ms O'BYRNE - With a paramedic assigned to monitor her.

Ms JENNINGS - Yes, to alleviate that fear that you have in your mind of was she alone? They did talk about that, but they didn't really explain what physical space she was in.

Ms O'BYRNE - Okay, so you don't know how she transitioned through.

Ms JENNINGS - Look, they may have and they may not, and I may not remember.

Ms O'BYRNE - That is fine.

Ms JENNINGS - In fairness, I shouldn't say that they didn't say that.

Ms O'BYRNE - But that wasn't in the root cause analysis? They didn't address her journey through the care model at all?

Ms JENNINGS - No, I don't think so.

Ms O'BYRNE - The hospitals talked a lot with their staff about the 24-hour pathology model. Did the minister indicate that they'd done any work already? This is not a new issue, this one's been around for a little while.

Ms JENNINGS - Well, we hoped that. We thought, surely, we're not the first people bringing this up, because we're just people who aren't in the medical field, so surely someone has popped it in.

Ms O'BYRNE - But there was no indication that there'd been work done in the past?

Ms JENNINGS - No, there was no discussion about that. We did find that a little odd, because it's obvious to us and we're not involved in the medical industry.

Ms O'BYRNE - It sounds like they're treating it as a new initiative, for the first time, that's how it felt?

Ms JENNINGS - Yes, that they would look into it, that sort of thing. When someone says to me, 'I am going to look into that', to me that intimates that they haven't before, but they will do now.

Ms O'BYRNE - Were they in contact with your dad during the time your mum was on the ramp, or was she left and then he gets a call sometime after 7.22 in the morning?

Ms JENNINGS - Same, yes, they called him at the same time. They may not have called my dad because my mum may, and I only guess this, may have told them not to because he has -

Ms O'BYRNE - That is not uncommon, people do not want to bother people.

Ms JENNINGS - - and he has early onset dementia, so it would have distressed him greatly. My mother was very much the sort of person who would say, 'I'm fine, I'm fine, you don't need to worry about me'.

Ms O'BYRNE - Still, there are processes.

Ms DOW - That goes to my further question, Stella, during your meetings with the hospital executive and the minister, did they talk at all about reviewing the process of contacting next-of-kin or people's families to make sure that they are aware of what's happening with their loved one?

Ms JENNINGS - I would have remembered if they talked about that. No, there was no talk about that.

Mrs ALEXANDER - Stella, from the moment when your mother passed away until you had the first meeting with the minister, how much contact did you have from the hospital or from people in the Health department?

Ms JENNINGS - It was about two weeks after her death that the hospital contacted me to tell me that there would be a root cause analysis done and they explained what that was and what the process would be. That happened, as I said, in November, where we met and they told us the outcomes of that. They did offer at the end of that meeting and said if I had any further questions or I wanted to speak to anyone that I could contact them or they would arrange a time for them to follow up, but we declined, in fairness to them. We walked out of that meeting feeling - I don't know if we felt we hadn't been heard - that they hadn't been transparent in giving us enough detail.

After the root cause analysis, we also heard from the Coroner's Office. The Coroner's Office was excellent, and I can't speak highly enough about them. That must be a very, very difficult job to do, day in day out. They contacted us and said that they were going to be starting that review. They explained the process. Maybe about January they contacted us again and said that they had the specialist report. That then goes to the Coroner, which is usually the basis for the final report. They were happy to talk that right through. They read it through to me, they let me ask questions, they were really good. They also let me know that they would be in touch before it was released to let me know the dates and make sure that I was prepared because she warned me that there might be press that would want to speak to me about that.

She tried really hard to prepare me as best she could for that. She was very good. They continuously updated me as to what was going on with the Coroner's report, when it would be due, when it came out they confirmed with me on the day that it did come out. It was after the Coroner's report had come out that the minister contacted me to ask me if I would come meet with him.

Mrs ALEXANDER - How soon after the report was released and you had the opportunity to understand the details, how quickly after that did you meet with the minister?

Ms JENNINGS - It was pretty soon, wasn't it? 24 August we had the meeting with the minister, and it was 1 August when the report came out. Three weeks.

Ms O'BYRNE - Who initiated that root cause analysis meeting that you had two weeks after your mum passed away? Had you already raised your concerns, or did the hospital come to you cold and provide that information?

Ms JENNINGS - They came to us. We did not realise that -

Ms O'BYRNE - You just assumed that things had progressed?

Ms JENNINGS - We didn't even understand to begin with that there was a potential problem, in that sense, so when we went there on that morning -

Ms O'BYRNE - That would have been quite a shock to suddenly find out all that information.

Ms JENNINGS - Yes, it was quite overwhelming, to be honest. When we went to the hospital that morning, they were very much like, 'We did all we could, there was nothing else that could've been done. These things, sometimes they happen and we're very sorry'. We said we're sure you did all you could. We left the hospital obviously devastated, but not understanding -

Ms O'BYRNE - But not realising something had -

Ms JENNINGS - Yes, been amiss. Then, all of a sudden we got a phone call, I think, and then a follow-up email from the hospital about the root cause analysis. I remember when she called, I was so confused. I wondered what it was and why they needed to do one? It was quite vague. She said that when someone passes away unexpectedly we have to do a root cause analysis and then we review that to make sure that all best practices were met and we sometimes talk about them with the medical team to improve training outcomes and so on. It was quite vague and we were quite confused.

Mrs ALEXANDER - That communication seems to me quite cold and not really taking into account your feelings and your state of confusion. Is that correct, my assumption?

Ms JENNINGS - Look, they used the right words and they're very sympathetic and 'I'm sorry for your loss and I understand'. It was not clear to us.

Mrs ALEXANDER - It was not fully explained, especially in the early stages, what the process was.

Ms JENNINGS - No, I agree 100 per cent with that.

Mrs ALEXANDER - Therefore, you feel that you went into that meeting not being totally prepared as to what questions to ask, what information you will be receiving, and how to process all that was put in front of you?

Ms JENNINGS - Yes. We are both educated people. When I got the email I showed my husband and I said, 'Am I - just me? I do not understand'.

Mrs ALEXANDER - Giving you information you didn't have. Yes.

Ms JENNINGS - He read it and said, 'I'm not really sure either, it doesn't seem right'. Again, we didn't feel like we were getting the whole picture at any time. Even after we went to that meeting we still felt like we only had part of the picture. As it turned out, we were quite right. We never understood why they were so opaque, because they knew at that stage that there would be a Coroner's report. They knew that it would come out. I'm not sure what the plan or the end-game was to only give us a certain part of that picture that they wanted to show us, knowing that in the fullness of time everything would be public.

Ms O'BYRNE - Had they spoken to your dad?

Ms JENNINGS - No.

Ms O'BYRNE - They always went through you?

Ms JENNINGS - That was at my request and at dad's request, because he was devastated.

Ms O'BYRNE - Yes. So, there was no other way the information could have been given. That is fine.

Ms JENNINGS - No. I am an only child; it's just me and my dad. I spoke to my dad at the beginning and said I thought something was wrong, and he was really upset and said would I look after it because he was already in pieces.

CHAIR - The Coroner was very clear that there was substandard accuracy in the record-keeping, not just about what happened to your mum but about the treatment that she received. As well as potentially compromising her treatment, it made the job of the Coroner very difficult to do properly. When you said, I think, that the minister had said that everything was fixed now in the first phone call, the first conversation that you had with the LGH and the medical director and Ambulance Tasmania -

Ms JENNINGS - Yes, they were saying, 'We've got this process now where there is someone to double-check that this follow-up phone call has been made for pathology'. They felt like that was fine and dandy. I thought that was simplistic at best.

CHAIR - Then they did the root cause analysis after that time? The root cause analysis hadn't been done in that first conversation that you had with the LGH and the medical director?

Ms JENNINGS - No, it had. They went through that with us at the first meeting at the hospital in November.

CHAIR - That's when they said it's all been fixed now?

Ms JENNINGS - They said they'd fixed this gap in the communication where they had to follow up the pathology results and they felt that that was the key critical issue that had affected my mum.

CHAIR - They didn't talk about the problems with their medical record keeping?

Ms JENNINGS - No. We also questioned at that time why she was not given the drugs. They said they'd needed pathology results because they couldn't give her the anticoagulant drugs that she needed. We did question that at the time and they said it was something that they couldn't have done, yet when the Coroner's report came out the Coroner mentioned that they should have just given her the drugs.

At the initial meeting at the LGH they said that the drugs could have serious side effects so therefore they waited on the pathology. Even had the pathology come back they would have then referred her to radiology to have a scan but she never even got that far. They mentioned none of that in the meeting. When I brought it up, they said no, that was not something they should have done, and yet the Coroner came out and said yes, they absolutely should have given her the drugs and it probably, in all likelihood, could have saved her life.

CHAIR - Is there anything else that you can think of that should have been in that root cause analysis? You might not have them all with you now, but it would be interesting to get

your perspective from what you know now what you think should have been in that root cause analysis.

Ms JENNINGS - I would have to go back to it. It is not something that you want to re-read as a family member, to be quite honest, and I haven't done so since I had to. I would have to go back and read back through it.

CHAIR - You do not have to do that, that's fine. I just wondered if something else had come to your mind.

I want to talk about the small changes that you said could be made. Would you say that attention to medical record keeping and some investigation into the processes around the medical record keeping - on the face of it, it sounds as though understaffing and pressures of staffing were possibly reasons, but there might be other deeper problems in addition to that about some problems around the protocols around medical record keeping?

Ms JENNINGS - Of course. How can you provide adequate care and continuity of care if you don't have available accurate records at your fingertips? To me, that's common sense. I can't tell medical professionals how to do their jobs, but I have worked in administration all my life and I would say that's a pretty obvious call.

CHAIR - The other is about the amount of nursing staff that are available. You don't really have information about this because you weren't on the ramp, but the minister or somebody said to you that there was an increase in consultant numbers from two to three. What do you think they meant by 'consultants'?

Ms JENNINGS - I assume it's like senior doctors that are on staff at the emergency department. Fiona Lieutier told me on Friday last week that it was a direct result of the review into my mother's death that they had increased the number of consultants in the emergency department from two to three on shift.

CHAIR - That sounds like a good thing, but it's also pretty clear from the Coroner's report that the absence of a cardiologist was very concerning. Much of the treatment of your mum would have been done by nurses, like providing different drugs and doing checks. That isn't something that you understand has changed at all?

Ms JENNINGS - No, I don't think it has. I have given the minister and Ms Lieutier every opportunity to tell me that if that was the case. I am sure, given how speedily they responded to me after I'd left a message indicating I was speaking here today, that they would have been quite keen to give me any good news or updates.

CHAIR - When they said they were advertising for qualified staff, did they -

Ms JENNINGS - They didn't say that, they said they haven't. Yet they kept saying to me that they can't source adequately qualified staff. I kept saying, 'but have you tried, have you actually advertised? Because I don't understand how you can tell me that you haven't got any suitable applicants for a job that you haven't advertised'.

CHAIR - When they said 'staff', who do you think they meant?

Ms JENNINGS - Sorry, in terms of?

CHAIR - Qualified staff. Hospitals have got cardiologists, doctors, nurses pathologists and radiologists.

Ms JENNINGS - Oh, qualified staff. Yes, we were talking about pathologists and radiologists. They were the two things we kept focused on. I have, as I've said, kept a fairly narrow focus on those two issues on purpose.

Ms O'BYRNE - When they talked about the support that your mum got and the consultants, was it ever made clear to you whether they were permanently employed staff specialists, or whether they were locum staff? Was that something that was addressed at all?

Ms JENNINGS - I didn't think to ask that, to be honest.

Ms O'BYRNE - No, that's fine. It triggered me when you said about continuity of care, and even that thing about not following up on the pathology report, I wondered whether or not that was an issue in terms of the temporary nature of staff, that's all. That is okay.

Ms JENNINGS - I don't know, sorry.

Ms DOW - When you went to the hospital the morning after your mum died, was there any ongoing support provided to you at that time? Or were you given recommendations around where you could get support, given the shock of that circumstance and what that would mean for your family?

Ms JENNINGS - No.

Ms DOW - At the meeting that you had, which came as a shock to you, around the root cause analysis, was there ongoing support offered to you at that time? No?

Ms JENNINGS - That morning is a bit of a blur to me. I think they said to us if we wanted to speak to the hospital social worker we could.

Ms O'BYRNE - They have an ED-assigned social worker in those things.

Ms JENNINGS - That is true, I would say my recollection of that morning is patchy.

Ms O'BYRNE - Understandable.

Ms DOW - Do you think that would have been useful, after the meeting that you had around the root cause analysis and that was presented to you, do you think that would have been useful at that time, to have additional support offered to you? Is it something you would have taken up?

Ms JENNINGS - Personally, I don't think so. We felt that the hospital was not being transparent with us and that speaking to people within that same system -

Ms O'BYRNE - Bit of a trust deficit there.

Ms JENNINGS - That is a trust deficit, exactly, that's exactly the words I was looking for. There was a trust deficit there.

Ms DOW - It is important for us to know, thank you.

Mrs ALEXANDER - The Coroner indicated that the electrocardiogram and the echocardiogram reports were missing. Did you get a feeling that those investigations were actually performed, or was it just that the records were missing? Did anybody clarify with you that electrocardiograms and echocardiograms had been performed?

Ms JENNINGS - No, so I'm not sure. I am a generally optimistic person and I'd like to think that they were done, but I've lost a great deal of faith in the Launceston hospital, and I don't know.

Mrs ALEXANDER - So that was never clarified?

Ms JENNINGS - We didn't know to ask that. The problem is you have the root cause analysis meeting prior to the Coroner's report, so when you go into the root cause analysis meeting you know nothing.

Mrs ALEXANDER - You don't know what to ask.

Ms JENNINGS - You don't know what to ask because you don't know what has happened and the only person that's giving you any information on what has happened is the hospital, who are perhaps not thinking it's in their own best interests to tell you, 'Oh by the way, we also lost some documents and we didn't provide adequate care, and we think the Coroner is going to come back and pretty much tell you that we've contributed majorly in your mother's death'.

Ms O'BYRNE - Did they say that to you?

Ms JENNINGS - No. You don't know that is what the problem is. You go into the root cause analysis before you know the Coroner's outcome. I understand how it makes sense for the hospital but I don't understand how it makes sense for the family, because it is more confusing and ultimately a bit more devastating because you come away from the root cause analysis meeting thinking it's probably just a small error on their behalf and people make mistakes. You can kind of put that to bed in your head, like okay, it was tragic, but someone made a mistake. Then later on, months later, you get the Coroner's report and realise that is nowhere near the extent of the truth.

CHAIR - Do you think there should be another root cause analysis done at this point after the coroner's report? Do you think it should be a standard practice?

Ms JENNINGS - Maybe. I don't see how that initial root cause analysis, in retrospect, is helpful to either the hospital staff or to anybody else.

CHAIR - And an opportunity for the hospital to formally respond to the Coroner's report and talk about what the response will be and what they will be changing as a result of the recommendations of the Coroner's report.

Ms JENNINGS - Which seems to me to be the issue. They were telling us at the root cause analysis meeting that the purpose of doing this root cause analysis was to help prevent these issues in the future, to address staff training issues and so on. Obviously, the needs were far greater and the problems far more serious than that initial root cause analysis indicated. They have gone ahead and presumably they've said to us at that time of the root cause analysis that they have said to us that they have trained their staff to bridge this gap with this missing phone call follow up. That's been done and everything is okay now.

That is obviously the wrong message to have been giving their staff, if that's happened, which is what they said happened. Who is following up now that the Coroner's report is done, to update that root cause analysis or whatever the mechanism needs to be for the hospital to use this as learning experience for their staff, for informing budgets and all those sorts of things.

CHAIR - It has long been the case that coroners make recommendations and they fall off a cliff and go into empty space.

Ms JENNINGS - That is what worries me.

CHAIR - Having a formal link between a Coroner's report and the hospital and an update of the root cause analysis or a review and some open public report in response.

Ms JENNINGS - Yes. It keeps me up at night, that I've gone through all these meetings and read all these horrible reports and I have to live with that, we all do - my family - and we don't know, and history will tell us that that is exactly what is going to happen: absolutely nothing.

Mrs ALEXANDER - You have no confirmation from the hospital about how they're going to be implementing or addressing the Coroner's recommendations? You have not received any evidence?

Ms JENNINGS - Other than, as I said, Ms Lieutier did say they that they'd increased the emergency department consultants from two to three.

Mrs ALEXANDER - But something that is more formal? Closing that gap, closing that loop for you to have that confirmation in writing or in a formal way, that they have taken these findings and they are implementing what they need to implement?

Ms JENNINGS - And not just, 'oh, we plan to implement,' I think if it takes an extra six months to hear back, I don't mind, but I don't really want any more people telling me, 'I'm sorry for your loss and we are going to look into it'. I want someone to come to me and say 'I've done this, we've worked on this for the past six or 12 months or however long it takes and now we have reached a point where we have 24-hour pathology and radiology'. A concrete outcome.

Mr BEHRAKIS - This may have already been answered a second ago, but for clarity, you had the meeting about the root cause analysis and they said what they said and then the Coroner's report has come out later and said completely different things. No one from that team at the initial root cause analysis meeting, or anyone at the LGH, has reached out after the Coroner's report or had any interaction or conversation about what came out of the Coroner's report and the discrepancies between that and the root cause analysis?

Ms JENNINGS - Not from the root cause analysis team. We did meet with the minister and the LGH CEO, Fiona Lieutier and the head of the ED at that time, his name, my apologies, escapes me. We did speak to them at that meeting, but that was not at the hospital, that was at the minister's office.

Mr BEHRAKIS - Did they discuss the discrepancies between the Coroner's report and the root cause analysis?

Ms JENNINGS - No. We had a 30-minute meeting. As I said, I was pretty determined that I wanted to talk about the pathology and radiology.

Ms O'BYRNE - At any stage did they talk about the role of the hospital morbidity committee?

Ms JENNINGS - No.

Ms O'BYRNE - There has been no time at all, that you're aware of, of whether this incident, other than the root cause analysis assessment, has gone to the hospital morbidity committee for assessment, training, or review?

Ms JENNINGS - I do not know what that is.

Ms DOW - When you spoke to Ms Lieutier about what was going to be taking place, there was the additional consultant in ED, but she spoke about budget constraints and needing to put a submission in around 24-hour pathology and radiology. Did she give you a time frame? Did she explain what she meant about budget constraints or what that meant?

Ms JENNINGS - She just said she was concerned that there would be budget constraints because the cost for having 24-hour radiology would be double the current budget.

Ms DOW - Double?

Ms JENNINGS - That's what she said. She said double.

Ms DOW - Did she say similar things for pathology?

Ms JENNINGS - She didn't say about pathology. She just said that she hadn't even put in a submission for the pathology because she was awaiting the results of a state-wide review.

CHAIR - What was the state-wide review into?

Ms DOW - That would be the ED departments, wouldn't it?

CHAIR - She didn't say what that was? Because parliament has called for a review into the Launceston General Hospital, but she didn't say if that's what she was referring to?

Ms DOW - Did she commit to coming back to you with some time frames around that or another meeting with the minster?

Ms JENNINGS - She said that I was welcome to call her for updates and she would be happy to discuss them. She didn't offer to do that, she offered for me to call her if I didn't get a response that way.

CHAIR - We talked about the trust deficit before. How has this impacted how you feel about going to the Launceston General Hospital?

Ms JENNINGS - We are terrified that one of our kids or one of us will be sick or Dad is not in great health, and it's terrifying. I have to go to the hospital, I don't work in the medical field, but I work through the NDIS and I quite often have to visit the hospital to see some of my participants there, and it makes me ill. I feel sick walking into the hospital just for my participants, imagine if it was my family. It literally keeps me up at night, worrying. If the kids ger a little bit sick I think - I'm not a panicker, I'm not that kind of person. My children are not tiny. I was never this panicky even when they were babies, but now I worry that they just aren't going to get the care. We were so blithe about it.

We lived in Melbourne many years and we moved here four years ago. I love Launceston, and we love everything about living here. We just didn't realise that the health system, comparatively, is in such bad repair. So many things are falling through cracks. So many things that just aren't there that you'd expect to be there are not. I don't know what we'll ever do if one of us has to go to the hospital, but I can tell you that we are all really anxious about that in our family now.

CHAIR - What would give you some more confidence? What would it take to change that feeling?

Ms JENNINGS - It needs to be a more transparent system. You hear in the news there is going to be a review and they are going through this and that, and I understand that all has to happen, but maybe people reporting on these things and having that transparency and seeing some concrete outcomes. We all read that there's going to be a review and they're going to look at this, but when do we ever see the news article that says, 'This is now being implemented, this is the change that's happened'. Perhaps that's because it's not popular to have good news stories in the news and it always have to be negative, but I'm not sure that shouldn't be something that is addressed so that people can see and maybe that's more impetus to do the things.

CHAIR - Thank you for talking to us today and sharing your story. Is there anything just before you leave that you think you might regret if you didn't say it to the committee, or something else that you would like to share, or any small or large ideas or things that you think you should say. You have given so much rich information.

Ms JENNINGS - No, I think I've said everything that I wanted to. Thank you again for giving me opportunity to do that, I really appreciate it. It gives me some form of closure to know that at least I am able to advocate for some change.

CHAIR - We will follow up on your submission. We will be making a report with findings and recommendations in it. Thank you so much, Stella and Joe.

Ms JENNINGS - No worries, thank you.

CHAIR - I advised you at the start of your evidence that what you said today is protected by parliamentary privilege. I am just reminding you that when you leave the table the privilege is no longer attached to any comments that you make outside to anyone, including the media, even if you are just repeating what you said to us here.

Ms JENNINGS - I understand. No worries at all.

CHAIR - Thank you very much.

The witness withdrew.

The committee suspended at 11.48 a.m.

The Committee resumed at 12.08 p.m.

CHAIR - Before you give your evidence, I need to ask whether you have received and read the guide from the secretary about the proceedings and parliamentary privilege. You get the protection of parliamentary privilege in anything you say to this committee, it means that it's a legal protection that enables you to give us evidence and to speak with freedom, without fear of being sued or questioned in a court or any place outside of parliament. It gives us the opportunity to get the very best information for our inquiry.

That protection isn't provided to you outside of this hearing if any statements that you make might be defamatory or if you refer to things you said in the committee, that also does not give you protection, even if you said them here. It is a public hearing, there is a journalist here, so your evidence might be reported. If you want to make any of your evidence in camera, that's not recorded, then you can let us know and we can organise to do that at the end of the committee.

Dr DODDS - I understand that, thank you.

CHAIR - Thank you for such a detailed submission. Can you make the statement?

Dr BEN DODDS, RURAL DOCTORS ASSOCIATION TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED**.**

CHAIR - It is a very rich submission. It has a lot of information and I don't know if you've prepared a statement, but I will just let you know that we've read the submission and we've got some questions. Did you want to start off by making a statement?

Dr DODDS - Yes, I do, I've got a short statement to make, just to set the scene, if that's okay?

I would like to thank the select committee for the opportunity to present to you today on behalf of the Royal Doctors Association of Tasmania. I am a rural generalist, which means I that have a specialist qualification in general practice, with advanced skills in emergency medicine in rural and remote contexts. I currently work in Scottsdale in the general practice in the North Eastern Soldiers Memorial Hospital, Launceston General Hospital Emergency Department, including as a medical officer in charge overnight, and work as a GP there as well as a consultant for THS North.

I think that, because of all those roles, I am uniquely placed to see the health system as a whole, from primary care, to urgent care, to emergency care, inpatient acute and subacute care and palliative care. As a representative of a membership organisation, I provide the views of rural doctors in Tasmania and supplement them with my own experience as working in the Tasmanian healthcare system.

As you'll know, our submission primarily focuses on the role of primary care and rural health services, and reducing ambulance ramping through providing alternative care locations closer to home for rural and remote Tasmanians.

State-wide, we have approximately 150 rural hospital beds, which is more than what the Mersey Community Hospital has, that is, we have a whole hospital's worth of rural health beds in rural and remote Tasmania across 13 communities. Unfortunately, you'll see a continued degradation in these hospitals, with a shrinking workforce, reduced service capabilities, lack of access to pathology and imaging, and minimal incorporation into the acute sector and long-term healthcare planning.

Tasmania has a significantly decentralised population, with some of the worst health outcomes in Australia. They have a high burden of chronic disease and we need a primary care service that cares for people in their local community with a mixture of multidisciplinary teams that meet the health needs of the community. This includes focusing on preventing disease, as well as preventing deterioration of chronic disease.

The submissions to this inquiry are harrowing, there is no other word for it. There is significant moral injury to doctors, nurses, and paramedics. That means we are losing workforce. Because they know that they're not providing the standard of care that meets the expectations of the community and is not the standard of care that we're held to in Australia.

Specifically, we've heard about long transfer times from patients in rural communities who bypass the local district hospital, as it is under-resourced and under-equipped to meet the patients' health needs. They are then ramped in emergency departments for hours on end, leaving huge geographical areas of Tasmania uncovered for emergency situations in the community.

When a patient is offloaded from the ambulance to the emergency department, that doesn't always mean they get a bed. It is common for patients to be offloaded into a ramping space to be cared for by the hospital, sometimes for up to 24 hours before an ED bed can be allocated, and another 24 to 48 hours for an inpatient ward to be allocated.

You will have read the experiences of patients who have suffered firsthand, including the unfortunate deaths that have occurred due to ramping. Specifically, at the LGH, we need to examine why there isn't 24-hour access to pathology and imaging, as well as extended-hours support for specialist consultation, allied health, and multidisciplinary care.

RDAT sees virtual care as an opportunity to help improve access and complement current health service delivery. We are concerned about the rapid expansion in this area, with multiple different programs existing concurrently, but we believe that there is significant opportunity to help our rural doctors care for patients in their local communities with virtual care, including accessing critical care advice, specialist consultations when required and allied health and multidisciplinary input for patients admitted to a district hospital. Most importantly, virtual care does not replace face-to-face healthcare provided by health professionals.

To address workforce shortages, we need to assure that we are selecting medical students, nursing students, allied health students from areas of workforce need - that is the north and north-west of Tasmania - support them to obtain educational levels and incentivise their transition to university. This includes delivering course material closer to home.

We need to ensure adequate exposure to primary care during their studies and during the first few years of work. For example, the John Flynn Prevocational Doctor Program allows

junior doctors working in general practice in a supervised and supportive environment, thus stimulating their interest in pursuing rural generalist medicine as a career.

Once again, I thank you for the opportunity to be before you today and look forward to our discussion this afternoon.

CHAIR - Thank you, Ben. I must say, it's quite painful listening to that statement, because your submission said there's a 50 per cent occupancy rate of district hospitals, but the number of rural and remote Tasmanians being admitted to hospital has risen by 20 to 30 per cent. Is that current?

Dr DODDS - That's correct, yes.

CHAIR - That's a massive increase, and we on the committee understand that is the case and the opportunities for care in rural communities is not being used. I find it really depressing, because I've heard so much conversation over the past decade about coordination, reviews and investigation into how we can use district hospitals and regional health centres better. Can you provide a little bit more detail about why you think - what is going on in that space? Why isn't it happening better? Who's not being listened to

Dr DODDS - I think it's to do with the governance structure of the Tasmanian Health Service in that the four major hospitals sit within the acute hospital sector and the district hospitals sit within primary health. There's two different parts of the Tasmania Health Service that are looking after the two different types of hospitals that we have, which means the acute sector and the primary care aren't always talking to each other. Which means that as new initiatives come through, like patient flow initiatives, we're not necessarily geared up to have the right governance structure to incorporate those district hospitals into the planning.

The other thing the Royal Doctors Association is concerned about is that there's a real lack of medical leadership and clinical governance of these district hospitals too. We've essentially outsourced the majority of the rural workforce to another organisation that provides the doctors for those communities, which means they're not part of the Tasmanian Health Service per se. If doctors want to have a voice and effect change in their local community, there are significant barriers to doing so, because they are not employees of the Tasmanian Health Service. Then when it comes to operational or strategic issues there is no level of clinical director or department head that represents doctors.

It goes from doctors working on the ground right up to the executive director of medical services with no intervening level that can help support our doctors on the ground. Which means that when we want to make change and want to support our patients and we say, 'we are seeing this, we think we need this piece of equipment or we are noticing there is a skill deficiency in this area, can we upskill in it?' It falls on deaf ears.

CHAIR - There's a few things in there. The acute and primary sector are separate and the district hospitals are part of the primary health care sector, so there's no conversation between the two, but there have been reviews into trying to use district hospitals. I remember them: under minister Ferguson there was a whole scale review about using them better. What would you recommend if you were giving advice to the minister about how to change it? There seems to be this never the twain shall meet. How can we bring them together?

Dr DODDS - We need to examine what those district hospitals and community health centres are currently doing, because I think no one really knows. They have historically branched out in their own way over a number of years through neglect and designed their own health service delivery without taking in the broader priorities of the rest of the health service. We need to examine what are those facilities currently delivering and what are the actual needs of the community now and into the future, and how we reprioritise and restrategise that for the future, and potentially standardise things a bit more too.

For example, in the north we have lots of different district hospitals, but they all have slightly different capabilities. It all depends on historical cultural things, rather than actual frameworks or strategic plans. Getting the stakeholders in the room to talk about what is it that we think the district hospitals need to achieve for the future? What workforce do we need for that? What infrastructure? What equipment? What skills do we need and what do the patients think at the end of the day? What care are they looking for in their local community? What do they think is reasonable to be treated for in their local community and what is reasonable to seek virtual care advice for and what is reasonable to seek advice in larger hospitals?

CHAIR - I assume there is an element of Commonwealth and state funding separation driving some of this non-communication?

Dr DODDS - One of the issues is our rural hospitals are staffed by general practitioners which are primarily funded under the Medicare model which means that the work that I do in Scottsdale is provided through Medicare rebates, rather than through being an employee of the state health system. This means if you're having issues engaging people from an industrial perspective, then the state doesn't have any interest in solving that because they're not currently paying for it.

CHAIR - How would you like to have a better relationship between primary care, rural doctors and the THS? How do you think that should happen? Would you recommend that some GPs might be paid by THS?

Dr DODDS - We have a bit of a hybrid system now where in some district hospitals they are, and in other district hospitals they're not, which makes change really challenging when you're dealing with different systems. RDAT is of the opinion if you're providing a public health service in a public hospital, you should be an employee of the public system. The multiple governors have sort of proven that's not a direction they're willing to take, with the outsourcing of rural workforce.

CHAIR - Why is that?

Dr DODDS - Because it's too hard to sort out the issues. Rural workforce is really difficult. We still see the same issues - staffing on the West Coast, staffing down south, staffing in the north-east of Tasmania - attracting and retaining and training a rural workforce is really difficult. I think Tasmania has shown we're not that interested in doing it ourselves; we're more interested in outsourcing it to a different organisation.

We have made some steps to try to train people - for example, with the Tasmanian Rural Generalist Pathway and the Rural Medical Workforce Centre at the Mersey. That's great whilst you're a trainee, but once you finish and become a specialist GP, you're then left into this lurch of so many different options, none of which make a whole lot of sense.

CHAIR - Who needs to be in the room to have those conversations about bringing those acute and primary cares together?

Dr DODDS - It starts with the Department of Health and its executive team; we need the leaders at each of the Tasmanian health regions; we need the doctors that are providing the services. We also need the nursing staff and allied health staff providing the services, as well as input from the Commonwealth as to how we're doing things in Tasmania and how models of care look differently in other states of Australia.

Ms O'BYRNE - That leads neatly to my question: who does it well? Who has a model that you would look at and say, I can see a really good integration between primary and tertiary healthcare?

Dr DODDS - I think every state does it differently; I don't know if one state does it the best. With rural communities, the old saying goes if you've visited one rural community, then you've visited one rural community. What works well in one community, may not be the right model -

Ms O'BYRNE - For a systemic model you're talking about need for a greater systems reform. So who would be closest?

Dr DODDS - Queensland Health would be the leaders in rural and remote. They've had the rural generalist model for nearly 20 years now.

Ms O'BYRNE - And they've got the base hospital model too, haven't they?

Dr DODDS - Yes, they do. They've got their clinical leadership as well, with having a medical leader at each site that reports to a director of medical services for the rural part of their health service, who then reports to the higher levels of the executive. They have a very clear delineation of leadership and roles within their health service. In areas where it is hard to recruit, areas where there's been market failure - we use communities like St Mary's or Ouse as Tasmanian examples - then the Queensland Government takes on the ownership of employing the doctor across both the hospital side of things and in the primary care side of things, to guarantee stability for that community.

CHAIR - So it can be done, there is a model.

Ms O'BYRNE - I was just going to ask, because when we've compared provision of health services in Tasmania, we often look at the cost of provision of healthcare services in northern Queensland and northern Western Australia. That similarity is quite strong.

Fundamentally, though, primary care is a federal government private business model around GPs. It's also that connect between the GP service you would want to run and your relationship with the community hospital. Because neither one is a big enough job. Did you want to talk about how that might connect?

Dr DODDS - Yes, absolutely. We talk about training rural generalists who can provide primary care through general practice, they can provide hospital-type medicine, and they

usually have an advanced skill that meets the needs of the community; whether that's anaesthetics, obstetrics for birthing, emergency medicine.

The difficult thing about rural and remote is you can't ignore the fact some of that's Commonwealth-funded and some of that's state-funded. In examples where it's worked well, the state has taken ownership of that service and has used some of the income from the Commonwealth to supplement it, because we know through the Medicare system, it is simply not viable to run a solo rural generalist practice.

Ms O'BYRNE - That's the block funding model that allows for that, or not?

Dr DODDS - Block funding for the rural hospital, but there is a system where the practitioner can claim Medicare billings and assign them to the state to offset salaries, incentives, allowances and things like that.

Ms O'BYRNE - You can't do in an acute hospital, like the LGH can't claim Medicare?

Dr DODDS - The LGH can claim Medicare if patients have elected to be treated as private patients within the public system.

Ms O'BYRNE - That is a different thing to a Medicare rebate though, that the GP collects?

Dr DODDS - That's different.

Ms O'BYRNE - We're using similar language, but they're different things, there's multiple funding sources?

Dr DODDS - There is. To claim a Medicare rebate as a general practitioner whilst also being paid by another entity, there is a specific exemption under the Health Insurance Act. That's the basis of the single employment model in Tasmania. The registrars are employed by the government, paid a salary under the industrial award; they will claim Medicare benefits, and they will assign them and it gets sorted out in the background as some to the practice and some to the health service. There are ways of doing it.

Ms O'BYRNE - But it's complex.

Dr DODDS - Yes. There are other communities that specifically use this - what we call 19(2) exemption - to fund their community care.

Mrs ALEXANDER - Thank you, Chair. Two questions for me - mainly because I'm trying to clarify - the district hospitals, are they funded on a model of per-bed day occupancy as well?

Dr DODDS - No, my understanding is they are funded as block funding. Regardless of if you've had one patient admitted or 2000 patients admitted, the funding would be the same to keep the doors open.

Our concern is that block funding exists for the inpatients that are admitted, there isn't necessarily any extra funding if you see an increase in emergency department presentations.

For example, St Helens in the summer becomes a very busy district hospital as that population swells. They can see up to 500 patients a month through their emergency department, but there's no extra funding to facilitate extra nursing staff or resources taking care of those admitted patients to come to the emergency department and assist.

Mrs ALEXANDER - Do you believe the block funding for the district hospitals is, in effect, hampering the capacity for district hospitals to progress and offer better services?

Dr DODDS - I don't have a clear understanding of how much block funding the district hospitals get. I'm aware that Primary Health, as part of the Tasmanian Health Service, has a budget that would be dictated by how much block funding they receive. When we, as rural doctors, request extra services, infrastructure or equipment, those requests are usually denied to a lack of funding.

Ms DOW - On the equipment and the inconsistencies across each district hospital site across the state, for the purpose of the committee could you outline some of those discrepancies for us and any interaction you've had with the Government about seeking further funding for those specific pieces of equipment, or procedures to be undertaken at those sites?

Dr DODDS - Different district hospitals have a wide variety of different equipment and then arrangements for operating that equipment. For example, on the west coast, the imaging equipment is owned by the hospital, but the operation is outsourced to a private entity. That private entity is there for one-and-a-half days a week. If you fall off your mountain bike and break your arm, you'll want it to be a Wednesday afternoon; you don't want it to be any other day of the week. The pathology, again, is outsourced to a private operator who can run a different level of tests in Queenstown to what I can run in Scottsdale, because we do it in-house. There discrepancies there in what you can actually access as a patient coming to a district hospital -

CHAIR - Different as in more extensive?

Dr DODDS - I wouldn't say any of it's extensive; I'd say it's all bare bones, but some facilities are worse than others. For example, if a patient turns up in Scottsdale and I'm worried they have an acute infection, I have no access to any pathology that can confirm they've got an acute infection. I have no access to x-ray after hours and currently have no access to point-of-care ultrasound to assist my management.

And there are discrepancies in what the THS has funded over the years. In the north-west, all the district hospitals purchased quite expensive point-of-care ultrasound machines, which are consistent with what we use in the bigger emergency department. Then in the north, we haven't gone down that same line; we've gone down with cheaper, phone-sized models of point-of-care ultrasound. We're talking differences of $80 000 in expenditure per hospital just based on the region you're in, without any real strategy as to what the future holds for those sorts of purchases, or going through a type of lifespan with them and replacing them into the future.

What rural doctors are really frustrated with is that they walk into a district hospital in Tasmania and every hospital they walk into is different and has different access to equipment, different staff, different skill mixes and different access to ambulance transfers.

We'd like to sit down and have a conversation - back to the earlier point - about what it is that we actually need in these district hospitals. Let's look to examples on the mainland for similar-sized communities, what's the expectation of patients, where's the evidence at for some of this equipment that we're using now, provide patients with the care that they expect and they deserve when they present to a district hospital and allow rural generalists to work to their full scope of practice.

CHAIR - Do you think a review into that would be a complex and extensive process?

Dr DODDS - No, I think it would be fairly straightforward to understand the infrastructure, the technological capabilities and the medical or point-of-care equipment that's available to each district hospital. I think that would be an interesting exercise to map that across the state.

Ms DOW - The current Government has said they are going to do a master-planning exercise across district hospitals and they're currently undertaking a review of emergency departments across the state. (a): do you think that first piece of work is adequate and have you had input into the design of that work, and (b): are you having input into the review of emergency departments from a rural doctor's perspective?

Dr DODDS - My understanding of the district hospitals master planning is that it's budgeted for the 2023-24 financial year. It's been allocated a budget of $500 000, which will be inadequate to complete that work. We're spending millions of dollars on master plans for Burnie, Mersey, the Royal Hobart and the LGH, so $500 000 for 13 district hospitals will be woefully inadequate to decide what their needs are for the future and what their infrastructure needs are for the future.

Because that work is yet to have started, we have not been engaged as the Rural Doctors Association to participate in that exercise. Through my role in the Tasmanian Health Service, I have been engaged in some of the mapping and understanding of our rural communities and what services currently exist, what the utilisation of those services are and we hope that there will be a report into that released before the end of the year for us to review externally as an organisation.

CHAIR - Half-way through the financial year and you haven't even had contact. That's depressing. I want to talk about your recommendations about allied health. You've said the discharge process is hampered by a lack of allied health professionals being available to support people while they're in hospital and then transition them out and be available for them in the community, particularly rural and remote patients. Can you talk a bit more about what you understand those specific gaps are, if you have any information about where they're happening around the state?

Dr DODDS - One of the concerns is that we still run a 9-to-4 or 9-to-5 health service. There is very minimal access to allied health or specialist consultation in the after-hours period. As we'd all be aware, patients don't turn up between 9 and 5. They have care needs all day.

I can give one specific example from working over the weekend. There was a gentleman who had sustained a fracture in his cervical spine, who required a specific brace or collar to be fitted. That fitting can only be done by someone who's trained in orthotics to complete that fitting. Because it was a long weekend, that service was not available until Tuesday morning.

So, he had an extended stay in the emergency department awaiting the person who could fit this, when otherwise he could potentially have gone home.

CHAIR - Allied health comprises many different professions.

Dr DODDS - They are all important.

CHAIR - In terms of discharging patients from hospital would you say that's the kind of priority area that we are deficient in, or is it more about the funding and having people available in the community?

Dr DODDS - I think it's about supporting that transition to home, which means that when you go home, your care doesn't stop. What we see a lot of is that you might actually get really good, intensive allied health interventions during hospital to try to support your transition to home as well as you can and then people get home and that support has fallen off.

One of my patients in Scottsdale recently had a stroke that left him with vision impairment. He had great allied health interventions when he was there, but when he got home there was no occupational therapy to assist him with his house; there's no social work to assist him with the fact that he can't work, and he needs to apply for Centrelink benefits; there's no linking with the Blindness Society to support this man; there's no linking into psychology, because we know that people who have had strokes are more likely to get depressed. All those things, as patients transition into the community, don't exist. If they do exist, they're overrun. If you're in a rural and remote community, they won't exist at all.

CHAIR - What's happened to him?

Dr DODDS - He sees his GP and the GP fixes all the problems, because that's what we do. We're fixers, aren't we? No, I support him by spending 45 minutes filling out Centrelink forms. I stay back late at night to fill out NDIS forms. I ring the Blind Society to see if they can provide support to this gentleman. He's too young to access aged care services unfortunately, but that's something that you would help organise people as well - getting in for aged care assessments and supporting them at home. This is where general practice becomes the default fall-back position for when acute hospitals fail to support transition back to the community.

CHAIR - Unsurprisingly.

Dr DODDS - Unsurprisingly. And for patients, their anxiety is only exacerbated by the fact that they are discharged and told to see their GP and it might be a six-to-eight week wait to see their GP at the moment.

CHAIR - You mentioned in your submission that the problem with continuity of care for people, the shortage of GPs and costs are especially prohibitive for many people in Tasmania in rural and remote areas. That leads to an exacerbation of chronic disease which means that people end up in ambulances having to go back to the hospital. Is that the situation you are referring to, the lack of allied health support for people or is it just not enough?

Dr DODDS - It would be part of providing comprehensive primary care within a general practice that includes access to general practitioners, allied health and nursing staff as well. It would encompass all of that.

CHAIR - One of the other things in your submission is that you counter what you say is that the narrative which is produced by the state Government quite regularly and also by the Commonwealth Government that the ramping problem is caused by a failure in primary health delivery in the community and by the failure of GPs being there for people when they are needed. But you have separated the issue of people who turn up in emergency departments who need some primary health care and are very unwell and need a bed, and you point correctly to the fact that those people who are turning up for primary health care who would never need a bed and are [inaudible], do you want to speak to that?

Dr DODDS - I think it's a really important issue and it's the rhetoric that we hear. For example, four out of 10 patients presenting to an emergency department don't require emergency care. There are a few studies that have actually examined the way the federal government defines that, and have decided that, actually, of those patients that presented, a lot of them received a form of care in the emergency department that is not currently available in general practice. I've outlined a few of those in the submission.

There should be a very clear delineation that if a patient arrives or selects an emergency department for a non-acute issue that could have been managed better in primary care, they will not contribute to ramping or to access block, because they are not causing an ambulance to delay its offload, they are not using an emergency department bed, and they are not waiting for an acute inpatient bed. So that's that issue.

We do, however, acknowledge and recognise that if patients are unable to see their regular general practitioner - or at least their general practice at which their information is contained and they're known to the staff - they are likely to unfortunately experience exacerbations of their chronic disease and they can go unnoticed for several days to weeks, to the point where they become so unwell that they do require an ambulance, they do require an acute emergency department bed, and they are then admitted to hospital.

There is some discussion that could be had about whether admitting people to hospital in that moment is actually the correct decision. Do we look at sub-acute care within the district hospitals? Do we look at Hospital in the Home? Do we look at early discharge with rapid access to specialists' input in the community? There are alternative avenues as well, but that inability for patients to access their primary care practitioner is something that can contribute to ramping in that instance.

CHAIR - Thanks.

Ms O'BYRNE - I want to ask about offload delay but also the delay in getting there. In context, we often see photographs of eight or nine ambulances at the Launceston General Hospital (LGH). We only have four in Launceston so those other five are either anything that's come east of the Mersey, or our regional ones. You probably have a greater insight to what that means in Scottsdale because the GP practice, the ambulance station and the hospital are reasonably well located.

Dr DODDS - Close to each other, yes.

Ms O'BYRNE - What I'm wondering about is what kind of delays we're seeing before an ambulance can get to patients within your community, what the demand on GPs is during that wait and exacerbation conditions. Are we seeing significant rates of adverse outcomes because of that delay? How does that play out on the ground in a regional community when your ambulance might have to finish its ramping and get back to Scottsdale and/or you're waiting for the George Town one to arrive because the Bridport one's been sent to the West Tamar?

Dr DODDS - We'll acknowledge the fact that the Government has reviewed this issue and said, 'Look, there is a deficiency in some of our rural ambulance services and new stations are coming on line', which we're appreciative of. An example I can give you was shopping at the supermarket one lunchtime in Scottsdale and a lady unfortunately fell over in the supermarket and was unable to get up again and was concerned that she might have broken a hip, which is a common thing. We called Triple Zero for an ambulance and I think we waited about an hour or an hour-and-a-half for that lady to receive prehospital care with an Ambulance Tasmania paramedic. That is a case that we submitted to the Rural Health Services inquiry that you might recall, as well.

What that means essentially, as an illustration, is that patients can wait an hour, an hour-and-a-half or two hours before they can receive pre-hospital care with Ambulance Tasmania. When we look at ambulance response times - and we talk about eight minutes, 10 minutes, 12 minutes - it's hard to understand as the Rural Doctors Association what those numbers represent when we know that our patients are sometimes waiting hours for an ambulance. The effect, obviously, is that I stayed with this lady and ran late for my clinic, which is okay, it's what you do.

In terms of inter-hospital transfers, I think that's something really important to highlight. If I've seen and assessed someone in a district hospital and I've decided your care needs are higher than what I can currently provide in this facility, or you require an investigation that's not accessible to me, I request an inter-hospital transfer from my emergency department to the closest emergency department which would usually be Launceston from where I'm working.

Ms O'BYRNE - Can I check, so, if you saw them in your GP clinic, you would then get them into the North Eastern Soldiers Memorial ED in order to make that kind of transfer?

Dr DODDS - It depends on the acuity. If I suspect a heart attack in the general practice, I'd ring Triple Zero and ask for them to attend. If they're in the hospital then we ring a different number but at the end of the day it's the same crew and it's the same people coordinating it behind the scenes. It's just that the entry point is slightly different.

We're aware of data that suggests that the length of time patients are waiting for an ambulance transfer from a district hospital to an emergency department is increasing and has increased over the last five years.

CHAIR - Is that available?

Ms O'BYRNE - You said that in the submission. That's where I'm heading with this: how you collected that data.

Dr DODDS - It would be available from the Department of Health. They would be able to provide a number. I'm aware of those numbers through my role within the Tasmanian Health Service, so I haven't reproduced them as an RDAT representative -

CHAIR - [inaudible - the request for transfer.

Dr DODDS - Yes, so from the time of request to the time of arrival in the emergency department that's been requested, that length of time has increased significantly. We are now seeing wait times of a 100 minutes to 200 minutes, depending on where you're located.

That does impact on the way we need to run our service. An example of that is if you present to George Town with a suspected heart attack, best practice would be to get you to Launceston within 90 minutes of arrival to undergo an angiogram to remove the clot. If we're now waiting more than 90 minutes for an ambulance, do we now need to change the way we deliver our service, which is using thrombolysis or medication that breaks down the blood clot?

Whilst you're 45 minutes away from Launceston, because of those delays we are now changing the way we treat our patients. I couldn't tell you off the top of my head which outcome is better, but you can probably guess that getting to a cardiac centre within the shortest amount of time is going to get you better outcomes.

Ms DOW - Are you confident you have the provisions available to you to be able to provide that emergency care in Scottsdale should the ambulance be delayed?

Dr DODDS - No. Scottsdale specifically, yes, but other district hospitals, no. There is no real environment for us to discuss those changes that might be needed.

CHAIR - This goes back to your recommendation for a director of -

Dr DODDS - Essentially a director of rural health or a clinical lead for rural health.

CHAIR - GPs on the ground.

Dr DODDS - Correct. If GPs have noticed this, who do they turn to help solve this problem?

Ms O'BYRNE - I have one more question on that delay issue. You have your rural patient who may already be significantly delayed because the ambulance has to get to them. You then have the transport time, which is expected when you live in a rural community. What happens in terms of the prioritisation of that patient when they present at ED? If you have arrived at ED and you are categorised as category 2, because they know the distance between your original call and your response time was much greater, would that end up with a prioritisation or conceivably is there any difference to the way they are treated once they arrive at ED?

Dr DODDS - Yes. This is saying that once they have arrived at a major emergency department, does their length of time or their rurality influence the triage category? The answer to that would be no, because a triage category is based on an assessment at that point in time. If you are clinically unstable or unwell you will get a higher triage category. If you had been adequately stabilised and assessed at the district hospital, but you are here for an investigation

that is not available, you might actually receive a lower triage category than what you got at the district hospital, because some of that work had already been done.

Ms O'BYRNE - Do you see peoples' conditions deteriorating - more so in your regional services - a deterioration from the first phone call to the actual receipt of treatment in ED? Are we seeing for regional patients a more significant deterioration of their categorisation? So, you've decided that they're definitely going to be a category 2 when they turn up, but they are category 1 when they turn up. Is that something that you see much of?

Dr DODDS - The triage categories are allocated by nursing staff rather than medical staff.

Ms O'BYRNE - True, but you have a good concept of what that is going to be?

Dr DODDS - Yes. I think patients who require that transfer and have an extended period of time when they're not under the care of the hospital, do unfortunately have the opportunity to deteriorate, because they are not receiving the care that they needed to receive two hours ago.

Ms O'BYRNE - But that is an opportunity for it - are you seeing significant evidence of it? Obviously the longer you wait, it's going to be an issue.

Dr DODDS - I can't say I can recall a specific case to give you evidence about, just that there are cases where patients require certain medications, certain investigations that are not present in the district hospital, that they are then waiting hours before they get it in the emergency department, and there is likely to be an association with worse outcomes there. But it would be difficult to measure.

CHAIR - There are some big reviews that need to happen, obviously the work on a better-funded investigation into district hospitals is something that wants more than $500 000 by the sounds of it. Is there anything you can say about the small-scale things that could make a difference now, as well as the many good things you have talked to?

Dr DODDS - Sometimes we've just got to go back to basics, does that make sense?. One of the reasons we struggle in the Tasmanian Heath Service is we don't do human resources well. We don't do contracts, rostering, pay, leave, culture, all those basic organisational things could improve our staff recruitment and retention, which means we can deliver better services on time.

It also means we might have the opportunity to have more doctors who can rotate out to our district hospitals in their junior years or their training years, so that they can experience what it's like to live and work in the rural community, and they might decide to pursue general practice or rural generalism as a specialty choice for the future. It also means that we'll be able to get more multidisciplinary input into those sites as well.

The other big-ticket item we think would change things is reviewing the way we conduct telehealth or virtual care in these district hospitals. We would be much better supported and much more inclined to take on an increased level of risk by having patients in these facilities if we knew we were being supported to do so. Currently, you're not supported to do so, and if there was an adverse event, then it would be, 'Well, you're out of line because you kept this

person here'. Well, the system didn't have anything wrapped around us to support us looking after these patients in the community.

CHAIR - Both of those recommendations, in order to be successful would, in your view, rely on being driven with the involvement of the Rural Doctors Association, like for the THS in conjunction with the Rural Doctors Association to do a review of procedures from the lens of rural doctors about how they could improve the THS HR procedures?

Dr DODDS - Yes, I think clinician engagement is really important in this space, you need to hear from the people who are working on the ground. I think the Department of Health is making good progress with the health senate and its clinical networks to try to get more clinician engagement and voice into its health service planning and its operational delivery. We'd re-emphasise that it's an important step that needs to continue.

CHAIR - Thanks.

Ms DOW - The only other thing I wanted to ask you was about paramedic practitioner roles in regional communities - you made mention of that in your submission - and how you would see that model of care and whether that would actually - in the instance of your patient that collapsed at the local supermarket - whether having had a paramedic practitioner based in your community to work alongside your general practice would have made a difference?

Dr DODDS - It's worth exploring. The conversations I have with paramedics, unfortunately because they're on the ramp and we're treating patients simultaneously, is a lot of them feel hamstrung with their scope of practice that is currently available to them in Tasmania. Some of them have advanced, amazing skills from rural and remote communities around the country and the current scope of practice guidelines within Ambulance Tasmania doesn't let them work to their full scope of practice. We would support looking into how the scope of practice of paramedics in rural and remote communities can support those patients to stay within their community or receive care within the local community, or work alongside us in the district hospitals.

I'll give an example. If you've broken your ankle, it's all out of place, there's no blood supply in it and the best thing to do is to give someone a procedural sedation and reduce it. You can't do that in a district hospital because you are by yourself, you're the only doctor on and best practice would say 'one person to do the procedure and one person to do the sedation and the monitoring'. If you had an advanced paramedic practitioner who can come to the hospital and assist you with that and get an x-ray and it's fine, then they don't need to go to Launceston tonight. They can go to a clinic and follow up in a weeks' time. That would be fantastic. That would save so much time, money, transfers and delays and be really satisfying for those practitioners undertaking those procedures, and really satisfying for the patients who are quite scared of going to our major hospitals.

Ms DOW - This is my final question. You referred to that too, in your submission, and how you think people in your local community are fearful of presenting and often put off calling an ambulance because they worry about how long it's going to take or seeking medical assistance. Can you elaborate on that and the impact it has on regional communities?

Dr DODDS - It puts rural doctors in a really difficult place because they've assessed and managed a patient. They've come up with a conclusion that, 'I think you need this blood test,

ultrasound, I think you need to see the surgical team about this problem,' and patients just say 'I really don't want to. I really don't want to go to Launceston and be waiting for hours. I am not going to get any of these tests'. If you are transferring someone overnight they are not going to get the tests because there is no on-site pathology or imaging overnight unless it is critical or urgent.

Our patients are making decisions that, in our eyes, put them at higher risk, and by virtue of that puts us at higher risk if something were to go wrong. We wonder what standard we'd be held to if something went wrong if you had a conversation with a patient about going to a major hospital for treatment, staying locally or discharging home, and you give them options and they choose one of the latter two and something adverse happens. What position does that put you in? That is concerning patients being scared of what they might face when they walk in the door at Launceston General Hospital. I think clinicians are sometimes scared to turn up to work and see what they might face as they walk through the door as well.

CHAIR - It goes back to the moral injury.

Ms DOW - It does, not being well supported in your practice setting.

CHAIR - Thank you, for the work you do. It is really important.

As I told you at the start of the evidence today, what you have said has been protected by parliamentary privilege but when you leave the table you need to remember that privilege does not follow you outside. If you comment even about the things you have said today, you are not covered by parliamentary privilege. Do you understand that?

Dr DODDS - I understand that.

CHAIR - Good. We can stop the broadcast.

Dr DODDS - Thanks everyone.

The witness withdrew.

The Committee adjourned at 12.57 p.m.