THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON PUBLIC HOSPITAL SYSTEM MET AT HENTY HOUSE, LAUNCESTON, ON 11 AUGUST 2009.

Dr ROBERT PARKES, REPRESENTING THE AUSTRALASIAN COLLEGE OF PHYSICIANS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - I will formally open our meeting. We will defer the other items in our meeting today and go straight to our first witness. Dr Parkes, if at any stage you would like to give some evidence in camera, on a confidential basis, we can accept that but you would need to tell us and then we can go in camera in a process that gives protection. In this committee you are entitled to say and give us the evidence as you see fit. You can talk generally to the Press afterwards if they want to talk to you about what you have said, but just be careful in your comments to the Press on different issues. You are entitled to do that within reason.

The Royal Australasian College of Physicians have provided us with some written documentation which we have circulated to members. Doctor, could you now identify to us any issues that you want to refer to us in accordance with the terms of reference and then there are some questions that we would like to ask of you. I will leave it open to you at this stage to move forward as you see fit.

Dr PARKES - The document, I guess, is the party line which essentially states that the college sees itself as the body that should coordinate and manage physician education, both in terms of training and continuing education. They see themselves as having close links with university and academia and clearly that is a reasonable position. Indeed, in that document it is almost as though OH&S meets medicine, if you have seen the speak that goes into it..

There are a couple of issues that, partly as an individual and partly representing the college, I would like to bring to your attention. I will start by talking about our hospital and our current Director of Medicine, Alasdair MacDonald. He has been an absolute breath of fresh air for our hospital and he has had some issues which have been fantastic. He has kind of reunited medicine and nursing. There are a series of units which are a group of people into which he has incorporated senior nurses, so that every time we do a ward round there is a nurse at very senior level who goes round and coordinates. As you can understand, the nurses are becoming busier, they do not have time to attend ward rounds so this one person coordinates with allied health, with nursing and so on, and it has smoothed up the process immeasurably. Alasdair has had a lot of ideas; he has initiated an acute medical unit which effectively removes emergency medical patients from the Department of Accident and Emergency because accident and emergency medicine has grown up as a specialty which focuses particularly on different sorts of problems - for example, multiple trauma and acute surgical problems. He is trying to get that emergency side back into nursing. There is a push to do this around the country. I think there might have been some moves to do it in Hobart but I gather it has fallen over. He has been very innovative and I would like to congratulate him on what he has done.

I do not know if you have realised how far medicine has come in our lifetimes; we are of very similar ages. When I graduated we did not know that aspirin helped in heart attacks, we had no treatment for heart disease, we did not know about cholesterol. Some things, sadly, have not improved. All of that has happened and probably, in my clinical lifetime, anaesthesia has become safe, intensive care has been developed as a specialty and surgery has become routine. The risk of dying from a routine anaesthetic now is something like one in 50 000. So, partly through preventative things and partly through intervention, there has probably been about 10 years added to the life span.

The risk of stroke, if you correct it for age, has fallen by 90 per cent since I graduated. I used to see 30-year-olds with strokes. My father has his first heart attack when he was 35. You think of heart disease now as something that affects people in their seventies and eighties and it has just been fantastic. But there is a flip side and I do not know if anybody has brought it to your attention. The problem is that we are treating routine acute medical problems now of people in their late eighties, early nineties and there have been a couple studies, but one most recently, was published by the Australian Institute of Health and Welfare. If you look at it from the patient's perspective, they get to a stage where they are winding down and they do not particularly want a great deal done. Yet, there is no clear pathway for providing limits to care. There is no clear pathway for offering those options in a way that is non-threatening when they come into hospital.

There is a perception in the hospital, and I think it is true, that the Crimes Act still states that any act of omission or commission that results in the death of a patient is an offence. So there is a belief that every patient who comes to hospital must receive cardiopulmonary resuscitation in the event of their heart stopping. And you think it doesn't mean much, you can start their heart fairly easily. There was an interesting study that was published in the *New England Journal of Nursing* about 10 years ago that looked at popular television programs and the success rate of cardiopulmonary resuscitation and it was over 90 per cent. In real terms it is less than three.

Ms FORREST - I don't watch them.

Dr PARKES - I don't watch them either, but it's nice to know that there is some data coming out of it. The community has a perception that life is almost endless and yet people in their 80s don't necessarily want that and there is no real mechanism by which that can happen. Our hospital has a very good palliative service but it provides a consultative service and they are not able, by virtue of what they have, to care for patients whom they want to palliate or who don't want life-prolonging treatment. I dare say that Hobart has the same problem, being bigger but with similar resources. People who would like to come into hospital and be cared for through a nurse but not necessarily receive resuscitation, don't really have the opportunity to do that.

South Australia has some good legislation. It's not euthanasia, it encodes palliative care as a legal way of looking after people towards the end of their life. The kind of death with dignity that is coming before the House - in other words, the euthanasia bill - is a long way from that. I don't think that currently there is any legislation that encodes the ability for people to refuse treatment and provides good legislation for people to provide that care in the knowledge that they're not breaking the law. I may be wrong, but the last time I was involved in that was in about 1995 when there was a bill before the House. It

was effectively a palliative care bill and it was overturned. I don't think it got up, do you recall?

Mr WING - Dr Bob Brown brought it in; it was a private member's bill. I think it was debated in the House.

Dr PARKES - This isn't euthanasia, this is simply saying that people at the end of their life don't necessarily want a lot of things done, and to allow that to happen. I am sure you remember in your day that people who arrive at an emergency department immediately have everything measured - it is a very intensive intervention. What if people don't want that? There is no way for them to come into hospital and receive care apart from that.

Ms FORREST - Their option is not to come to hospital.

Dr PARKES - Yes, the option is not to come to hospital. The problem is that they come because they are suffering. If their breathlessness becomes so bad that they can't manage at home, they come to hospital.

Ms FORREST - Is this then an issue more about providing resources in the community and in aged-care facilities and where these people are for palliation, dealing with delirium, their nausea and pain?

Dr PARKES - That is a big part of it. The difficulty of aged-care facilities is that if an emergency happens they feel that they are in the same boat, so they call the patient's doctor and he says, 'Send them to hospital'. There is no good means of looking after people who don't want particularly active care. There is also the perception that even if the care is ineffective, that people can dial up whatever they want. That is the way the community is going but I question whether that is always the wisest thing to do.

I would suggest that perhaps some sort of death with dignity without euthanasia would be something for this committee to consider. Where that goes, which party will support it, I don't know. You may have heard just last week there was a patient in Perth in a nursing home, a 49-year-old quadriplegic, who is asking for the right not to be fed. He doesn't want a lethal injection, he just wants to refuse food. That has polarised the community so much it is terrible. The politics of it are obviously dreadful and I do not pretend to understand it but I think it is in everyone's best interests.

Mr WING - There was a play at the theatre here only a month ago, almost those exact circumstances.

Dr PARKES - I saw the film in 1980 when I was in intensive care training.

Ms FORREST - *Shadowlands*, are you talking about?

Dr PARKES - No, *Whose Life Is It Anyway*'

Ms FORREST - On a couple of points you raised, Dr Parkes, there is clearly a debate that needs to be had and one is about allowing people to die and not necessarily having to treat everything, particularly when they are very elderly. There is also the other end of the scale of very premature babies and what we do for those babies. I do not know

whether you want to add any more to that but there is also the point you made about there is no legal framework for allowing people to refuse treatment or to have treatment withdrawn in appropriate circumstances. It seems that that happens quite freely anyway in many settings but there is also the enduring guardian that people can appoint. That is a legal document and as long as people know that it is there and can access it, it can provide direction on the medical treatment that a person may or may not receive. Do you think the enduring guardian is an area that needs to be expanded perhaps, or is there another process that we could be looking at?

Dr PARKES - No, I think enduring guardianship is fine. Somebody has to appoint a guardian and somebody has to listen to what the guardian says and, sadly, some of my colleagues do see life as a never-ending process and they are disinclined to believe or to listen to the guardian and I have some difficulty with that. It is a question of more a carrot than a stick. I think the right of people to determine their own destiny is paramount but, having said that, would you provide a liver transplant for an 85-year-old patient, and the answer is no. Somewhere along that spectrum - and we have talked about premature babies -

Ms FORREST - Very premature babies.

Dr PARKES - Yes, very premature -

Ms FORREST - Twenty-four or 25 weeks.

Dr PARKES - I have been an intensive-care physician for 20-odd years and there are circumstances where continuing treatment is really a process of negotiation until everybody comes on board and realises that it is futile. At a cost of $5 000 or $10 000 a day for bed and breakfast you have to wonder, and to give you an idea how critical that is at the moment - I am not saying that the ICU does not need more beds because it does - but there has not been a major elective case done at the LGH for two-and-a-half months because the intensive care unit has been full of patients with emergency, life-threatening medical problems. That is what the director told me the other day.

Ms FORREST - Is it your view then, Dr Parkes, that if those people were able to speak, which they are not as they are ventilated generally, they might have said that they did not want this level of treatment?

Dr PARKES - I think there are some who want it when it is not going to work and I think that is not necessarily appropriate. Just the process of negotiation and deciding when this treatment is futile can prove to be difficult. I am not saying that it is easy and I am not saying that you can write a series of simple rules to do it but I think it needs to be considered because, as I am sure you know, 90 per cent of the health-care dollar in hospitals is spent in the last year of life. I think we need to spend that money wisely and that is more as a private citizen, I suppose.

CHAIR - I should imagine a lot of this discussion came out yesterday in the committee on the issue of Dying with Dignity Bill. You are working within the private system?

Dr PARKES - In both.

CHAIR - In both so you are across both areas.

Dr PARKES - I have a sessional appointment at the Launceston General as something called a general physician; we are the people who are on call for, for example, typically people with multiple problems, so somebody who comes in with a heart attack would be seen by cardiology and somebody who comes in with a stroke will be seen by the stroke unit. Typically we tend to see the more frail, elderly patient with multiple medical problems and again, it is a question of negotiating and the pendulum would swing from home to hospital and back. Typically we see young people with asthma, heart failure, respiratory failure, lung infections, diabetic emergencies and so on.

CHAIR - I take it, Dr Parkes, you would have a pretty good understanding of the changes that are going to occur at the Launceston General Hospital within the new buildings and new rooms et cetera. In your opinion and your understanding of what is happening there, is that likely to fix a lot of the problems we currently have with not enough beds or areas for bringing patients in?

Dr PARKES - I spoke here at a meeting a couple of years before I moved to Launceston and Peter Baume had left Parliament and was Professor of Public Health at the University of Sydney, I think. He made the comment and said, 'Let's suppose that theoretically you could devote 100 per cent of GDP to health. There would always be somebody putting up their hand saying they need more beds'. I think Alastair's done good things about bed management. There has to be some rationale but politically I don't know you do it. I really don't know whether you say, 'This person should or shouldn't get it', and I suppose Oregon is the best model for that, and even that falls over occasionally. Most of the States use a casemix model. Do you know about the casemix model?

Ms FORREST - Could you explain it?

Dr PARKES - The casemix model is simple. Basically the system stems from a theoretical project in the 1970s by a health academic in the US who defined a series of relatively homogenous interventions in health care. Firstly, there were things that were unclassified and they tend to be things such as multi-organ transplants, intensive care and so on. Then there were system-based classifications, so for example there is a gastrointestinal system and it is then split further into surgical and non-surgical. One of the more common things we do is take out a gall bladder, so removing a gall bladder without complications has a relatively homogenous use of health care resources, and that has a number which is called a 'diagnosis-related group', and there are over 600 of those.

A group called the Clinical Casemix Committee of Australia refined that and wrote the Australian book which defines what those things are. Once you have uniform resources you can then cost them, which is relatively simple to do. I was on that committee and the costing committee. You can work out what it costs to, for example, take out a gall bladder or treat somebody with uncomplicated asthma or bring somebody in for the day for renal dialysis. Accordingly, if you can cost it, you can fund it. You can say to people, 'We'll pay you to do 500 gall bladders a year' - or 38 hips or something - 'and we'll pay you this much money to do it because this is what it costs'.

I spent probably half my working life in the late 1990s working on a group of committees and going around the State trying to introduce that funding mechanism but it

fell over because one of the hospitals couldn't come in under budget. In other words, it was politically inexpedient for a hospital to say, 'No, we're not going to do that; we're going to cost you twice for exactly the same product'. It's not that you are comparing, say, a Mercedes Benz with a Hyundai; it's exactly the same product and I think it should be about the same. If they are funded, they should be funded properly. That funding includes education, research, occupational health and safety and all the things that you need in a hospital. I believe that if you're going to do it you really need to casemix fund it and that is a somewhat unpopular view with clinicians, I think it would be fair to say.

I think that's the fairest way to do it. Secondly, I think that it should be across the board. I think there are some shadow casemix funding going on in the State at the moment.

Ms FORREST - That's how the private sector still works, isn't it?

Dr PARKES - To a large extent it does, and the private sector's got a huge handle on cost. This committee I was on, the CCCA, had two private hospital representatives. They had a huge handle on what it cost and their funding models and so on, so they're actually very good at it, and in the private system nobody minds. It's streamlined, so a person comes in for surgery, they are operated on, the rehab starts the next day, and so on.

Ms FORREST - Is it fair to say, though, that generally speaking - and this is generalising - private hospitals don't take on those really complicated patients with a number of comorbidities who come in for a gall bladder removal? I know there's a DRG for an uncomplicated cholecystectomy and there's also a DRG for your complicated cholecystectomy, but at the end of the day the private hospitals tend to have more people who are likely to fit into that uncomplicated area so it's easier to work out what your funding is, and the public sector picks up all the rest.

Dr PARKES - Not necessarily. If you look at health matters, the cost, if you measure the cost through complicated gall bladder, it is about three to four times that of an uncomplicated one, but the last time I looked at this people who have had their gall bladder removed with problems represented only about 5 per cent to 10 per cent.

Ms FORREST - Problems with the procedure or problems with their health otherwise?

Dr PARKES - Both. Most of casemix is actually streamlining fairly simple stuff. It works well with surgery, if you look at it carefully it works okay with medicine, and obviously it works with things like obstetrics where most of it is uncomplicated.

Mrs SMITH - Dr Parkes, I'm presuming the experience you are talking about is generally around the Launceston area. Am I correct?

Dr PARKES - Yes, although I've had a bit to do with the rest of the State.

Mrs SMITH - We had evidence that one of the issues surrounding hospital waiting times, emergencies and so on, was that entire wards were taken up by bed blockage, with people waiting to go to aged care in particular.

Dr PARKES - Yes.

Mrs SMITH - We were told that it is equivalent to one entire ward for 76 days. So we have that in the hospital system where we have bed blocks because the aged care system cannot take the on-flow. Did you say there has been one elective surgery in two months?

Dr PARKES - One major elective surgical case - you'd have to validate this - that required post-operative intensive care.

Mrs SMITH - And there are no ICU beds because they're taken up virtually by palliative care-type patients.

Dr PARKES - Not necessarily palliative care, just emergency patients who come in off the street with a problem. Most people may take weeks to get that -

Mrs SMITH - Am I correct in presuming in the general hospital structure we've got at the moment that we have two particular issues in Tasmania? One is the bed blockage because of aged care, and the other is that instead of progressing our palliative care-type system in this State, we have seen an actual decline, and there was one here in Launceston closed, a five-bed private facility. So we're going backwards in that process because instead of growing them we are readjusting the finances and seeing them close. Is that a fair presumption?

Dr PARKES - That is a fair presumption. The other issue is that, contrary to what you might think, the average age of intensive care admissions to the LGH at the moment is 58. When I first started doing intensive care in 1979 in Brisbane, the average age was 57, so it really hasn't changed all that much, but with the technology we have now to look after people, they do get better; there's quite a good unit here. It may take weeks and weeks for those people to get better, so I think there really is a need for more intensive care beds in Launceston, if only to facilitate elective major surgery.

Mrs SMITH - In your opinion, are the buildings, add-ons and additions that we are going to see around the Launceston hospital going to solve the problem, or do we still have issues with staff, nursing, all of those that are not building-type issues? We tend sometimes, I think, to say 'Give everybody a building and they will be satisfied', whereas to me it is what is inside that building that is going to make or break your health services.

Dr PARKES - I think you are right. You can have all the bricks and mortar that you like but the real structural issue with health are the people on the ground. There are a couple of issues with that. The first is: where do you throw the money? In general it is the squeaky wheel, so people stand up and say we have to have these resources. There is the Federal/State thing. When you think about it there are five tiers of management until you can get past all that because there is Federal and State multiple levels. Where is that money being wisely spent to be of any help? You either abolish the Federal system or you abolish the State system. The problem is that the Feds don't know anything about running hospitals. They don't like hospitals. The only hospitals they will have anything to do with are regional.

Ms FORREST - They did dally with the Mersey hospital.

Dr PARKES - Yes, that is right.

Mr WING - So you would be concerned if the Federal Government decided to take over all hospitals in Australia?

Dr PARKES - Not necessarily. They would agree that they would need a management structure to be able to do it. You could then have a bit of uniformity and direct resources properly. As well as the LGH staff, I cannot see us ever doing well if we set up, for example, a liver transplant unit.

Mr WING - Would that need to feature more local management?

Dr PARKES - Yes. I came here in 1994 to effectively set-up the intensive care unit and was involved for some years in doing that. One of the difficulties was that local management had almost no time whatsoever. They were supported by very good business managers who could make very good business cases but they were unable to progress those because of difficulties, particularly at State level but also at Federal.

There is also the Federal-State cost-shifting. There is duplication. For example, a patient discharged from hospital gets a five-day course of medication. Part of that is to encourage them to go and see their general practitioner fairly soon but part of it is to limit cost. A patient was admitted ostensibly with appendicitis. It turned out that she did not have appendicitis; she had a gynaecological condition. So the plan was for her to be reviewed in gynaecology outpatients but they would not review her in gynaecology outpatients unless the general practitioner wrote a referral which then constituted an outside referral and therefore attracted the Federal Medicare rebate. They would not guarantee that the doctor to whom she referred the patient would see her. That is just wasting everybody's time and money. So you have people who are employed just to try to move money from the Federal to State and from State to Federal.

Mr DEAN - That coincides with other evidence to this committee, that there is shuffling of money all the time between the two. It is not conducive to good medical support.

Mrs SMITH - You have spoken very highly of Alasdair MacDonald. You commented that he has dome some wonderful innovative things in Hobart, but you think they have fallen over.

Dr PARKES - Some if it has fallen over; some has not been attempted.

Mrs SMITH - It sounds as if innovation comes with the individual. Unless it is firmly entrenched, when the individual leaves we go back to the old bad habits. We do have quite a turnover of specialists from career moves et cetera.

Dr PARKES - I think it is a fantastic little hospital. I did my medical degree in Hobart and my postgraduate training in Queensland and Western Australia and have been back here for 15 years. For its size, and the size of the town, it is one of the best spots I have ever worked in. We have a cardiologist, Dr Herman, who has single-handedly set up a world class angiography and angioplasty service. One of my colleagues, a gastroenterologist, Chris Middleton, decided to do a sabbatical and flew to America every Tuesday afternoon to learn advanced endoscopy techniques. He has passed that on to other people. Culture is such a bad word but it is really a culture of innovation. There is the research foundation which was got up and running through private funds and through

diligent work by people like Jim Markos. If you have a group of people who actually want to do things, then you can achieve very good things. By and large, with very little exception, I'd say that's the case with that hospital.

Mr WING - And orthopaedics as well?

Dr PARKES - Orthopaedics has been very innovative. It's fair to say at the moment, with almost no exception, that I'd feel comfortable being looked after by almost anybody in that hospital. Nothing's ever perfect, but it really is very good. Having said that, there is no intensive care unit because I blew the whistle on a colleague. I just privately make the point that perhaps the way whistleblowing was treated could be a bit better.

CHAIR - Do physicians and doctors have sufficient opportunity to have input into the operations and management of hospitals and so on? Are you listened to enough? Do you have the opportunity to have the input that you, as a senior physician, ought to have?

Dr PARKES - I have to say I am not particularly involved in the administrative side. There is a regular meeting of the Department of Medicine. People's views are canvassed and they're taken to the executive. To what extent those views are listened to at a senior level I honestly don't know, although I'd have to say that John Kirwan probably has his head screwed on the right way. He's sort of attuned to the whole concept of running a hospital, much more so than perhaps might have been the case a few years ago.

Ms FORREST - I just want to get around to the Federal versus State cost-shifting issue here, because it's been identified by many as an issue. We have the current Prime Minister and the Federal Health minister suggesting that they still have the big stick out there to whack the various States for not providing the health service they deem to be appropriate. What we really need here is a way forward, and I am trying to get your opinion on how that is best achieved. If we establish a federal system where the Federal Government runs health services, then in my mind it's all or nothing; you take the lot or you don't take anything. So they look after the hospitals, GP services, palliative care, community care, aged care, allied health - the whole shooting match is under their jurisdiction. In doing that, the cost-shifting disappears because it's all funded under the same system, but then do we potentially introduce another level of bureaucracy in doing that or do you completely remove any State influence at all? How could that be achieved, or do you give it all to the State, but then however do we fund it?

Dr PARKES - There already exists a federal system whereby things are costed and classified, so almost all ambulatory interventions are federally funded and costed. Psychology is now federally funded and costed. You now have access to see a psychologist, and that is at a federal rather than a State level. So there's a huge mechanism out there by which you can look at costing and funding. The problem is how, by attrition, you reduce the level of bureaucracy that is at a State level and at a local hospital level to allow all to be shifted to the Federal level.

When casemix funding was first suggested here, it was said that if you have more than four layers between the most junior nurse in the hospital and the CEO, four tiers of management, then your hospital would lose out. So the secret is not whether the State or the Feds fund it; the cost-shifting just mucks around with it a bit at the moment. The real issue is: how do you reduce the number of layers between the top and the bottom?

Ms FORREST - Regardless of the system.

Dr PARKES - Regardless of the system. So the Federal-State system moves money around. You've got Federal down to there, State down to there, then local, so you have at least three tiers of management, not to mention the Federal health people that are present and work in each State. It has to happen by attrition; you can't magically shift the money from one to the other, but that's where it needs to be re-engineered.

Ms FORREST - So do you think it should be all managed from one bucket of money. I know the States get - they always claim it is not enough - under the Commonwealth-State health agreement a significant amount of money that goes into the public hospital system, so even though the State run it they're still getting funding from the Federal Government to do it. How would it be structured?

Dr PARKES - The first thing is, what's the bucket of money buying? If you were a Federal politician or if you were the Federal Minister for Health or even State Minister for Health and you said, 'We're just going to throw so much money at the Launceston General Hospital', what are you actually buying for your money? Okay, so you talk about measuring outputs: how many hips are getting done and so on and at what cost. Therefore you don't really know what you're getting. One of the re-engineering systems is that there has to be a national system of measuring and reporting what you're actually getting for your money, before you even start paying for it. We sort of do that, but we don't really, and I don't think Tasmania provides case-mix reporting to the Feds at the moment; they didn't for some time.

Ms FORREST - How are they accounting for their spend now?

Dr PARKES - I don't know if they are.

Ms FORREST - That's why they want to have more of a look at it. Jane Holden is speaking to us so she'll know how they are reporting.

Dr PARKES - I think there needs to be a kind of national system. Everybody will say, 'Oh, there's this stuff at the edges, there's this and there's that. What about the person here'. As an example, there a few hospital beds in small peripheral hospitals. It was costing roughly 10 times the amount that it would cost for an episode of care, whatever that was - like managing somebody with pneumonia. It can be managed, for example, at St Marys or St Helens or Beaconsfield or George Town, but it wasn't in the Launceston General Hospital.

Interestingly, when I was looking after the intensive care unit, there was a patient who had a ruptured abdominal aneurism, which is a hugely dangerous thing to do. He was looked after, had good surgery, got to hospital. I think it took us about eight weeks to get him better and out of intensive care. He did get out and he went back to a very good quality of life. He and his wife three weeks later were campaigning about the fact that they were cutting funds to the St Marys hospital and how he'd be dead if he wasn't well managed in St Marys hospital.

Politics did win overall, but I think at a State and national level people have to start measuring what they're doing and working to get value for money. I think it might just start happening from there because what if the community knew? When I was measuring the cost of having an uncomplicated gall bladder done, it was about $2 500. Why should it cost $7 000 or $10 000, and where is the value? People aren't earning any more money from that. They're all getting paid a salary; it's just that it's costing four times more.

Ms FORREST - It is a big issue because all of my electorate has small rural hospitals in it, as does the east coast. It's one of these vexed questions where we have this widely dispersed population in Tasmania. We're not like most of other States where the majority live within a couple of hours of their capital city. So we have a number of small hospitals that do provide overnight beds at great cost, from what you say, so should we provide that or should we shut down St Marys and Queenstown? We did at Rosebery effectively, though they still have their capacity for a 23-hour stay. So what do we do? Beaconsfield and Queenstown would be a similar size, I think -

Dr PARKES - Beaconsfield is a good example, a place where people love their local hospital, and you know about Latrobe. Wherever the hospital is, however big or however small it is, they see it as a really important part of their community. They are usually fairly big employers, too. I think the LGH is still the biggest employer in Launceston, is it not?

CHAIR - Launceston General Hospital is top, I think, and council comes about second.

Dr PARKES - Firstly it feels fuzzy because you've got a hospital, it's got a bed and it smells like a hospital.

Ms FORREST - It's got 'Hospital' written on the outside.

Dr PARKES - Yes, and it's got that kind of antiseptic smell. So there's this kind of fuzzy feeling that it's somehow good, but again nobody tells you what is the quality of the service that you're getting, and nobody will do that. Can you switch the microphone off?

Ms FORREST - We can go in camera if you want.

Dr PARKES - Just for a moment.

CHAIR - Okay. The committee agrees that we should accept this evidence in confidence.

Dr PARKES - Getting back to the Richardson thing, I think you need three hospitals.

Mrs SMITH - You made the comment earlier that it costs up to 10 times as much in a regional hospital as in the large hospital. What do you define as small and large? What is the cut-off line in the delivery of appropriate health services to the people?

Dr PARKES - I think for critical mass in Tasmania there should be three major hospitals. Aligned with the Richardson report, people should have particular services. There should be good access to emergency services, for example, and there's not. There is good evidence, for example, that in an acute problem with a heart attack it is better to

intervene and open up an artery than provide a drug to break down the clot that occludes it. Does Hobart do that, do they have a 24-hour angiography service?

Ms FORREST - I'm not sure.

Dr PARKES - I'm not sure that they do.

Ms FORREST - I'd be surprised if they didn't.

Dr PARKES - I'd be surprised, but you'd be amazed at the excuses that people have for not doing it. It is certainly not available in Burnie. By and large you need good emergency services and then I think you need to streamline them. Launceston does orthopaedics. If you're going to have an intensive care unit you probably need a speciality that provides surgery that keeps the place open as well. Cardiac surgical services are well established in Hobart. Neurosurgery services are well established in Hobart and Launceston is a true general hospital. It has good cardiac non-surgical services, good angiography as well good general stuff, but maybe there is a role for Launceston, particularly as a geographic centre where services could be expanded, particularly elective investigational services.

One of the big difficulties we have here is the management of people with sleep apnoea, a huge public health issue. I think one of your colleagues suffered a terrible motor vehicle accident a couple of years ago. He was driving to or from Hobart and fell asleep as a result of sleep apnoea and was involved in an accident which did not only injure them but also somebody else. Most of that is unrecognised. We have a small sleep laboratory here, a small sleep laboratory in Hobart, but there is none, as far as I am aware, on the north-west coast.

Ms FORREST - They were operating at the Mersey some time ago.

Dr PARKES - There is one at the Mersey, with limited public support, yes.

Mrs SMITH - You said three major hospitals aligned to the Richardson report. What, if any, would be the role of some of these small regional hospitals, considering the cost factor that to get three major hospitals doing what we want them to do is something we cannot afford? Do places like Beaconsfield, St Helens, St Marys, Queenstown have a role or do we shut the doors?

Dr PARKES - They have to have a role because politically it would be impossible for them not to do so. I think that is a fair comment. The services they provide should be appropriate for the place. If, for example, there is no doctor available 24 hours a day, if there is not a senior nurse available 24 hours a day to provide supervision, then you could rightly restrict the services they provide. They can provide rehabilitation services and convalescence. The west coast is a bit different. There is now a fairly good aeromedical retrieval service. Again I pay tribute to George Merridew, who has really worked very hard at getting that going, and Andrew Hughes. There is a fairly streamlined retrieval service so what those services can properly do should be defined. I do not think there should be a great deal of difficulty or political difficulty. If experts say we should do this then that is what we should do. I think we could then say realistically that that is a service you cannot safely provide.

Similarly, I believe if the Mersey is an organisation where it is not considered appropriate to train junior doctors then the quality and quality improvement issues are such that there are some services they shouldn't provide.

Mr WING - I empathise with what you said earlier about feeling comfortable in being treated by anyone at the Launceston General Hospital. We are very fortunate to have the high degree of expertise that we have in so many areas. But I am concerned about the emergency and accident section. I know personally of cases where people have gone there and have waited some hours before being seen by a doctor or even a nurse. We have had evidence about the problems those running that section have through lack of resources. Would you care to make any comment, particularly having managed that section yourself?

Dr PARKES - When I am on call we always do a ward round and see every patient who has been admitted in the last 24 hours. Typically we start our ward round in the emergency department because of this issue of bed block when people can't be transferred immediately to wards. Emergency departments are so far in left field from what I do. I do not understand how people think or work. It is almost adversarial. It is almost as though there is a culture of trying to keep people out rather than welcoming them in. If I am stressed or busy and running behind time and a new patient comes in, the way I can best relax is to see that patient and do my best for them, because that is what I do and I do it pretty well. Most people are stressed; they don't actually want to see patients. I really don't know how you turn that around because I think there is an element of that. It isn't just there; it is in most emergency departments. I think there is the stress of someone threatening to beat you up at 3 a.m. in the morning - everything about it. Non-urgent patients present because they can't get an appointment with their general practitioner. People present when they are fuelled by drugs, alcohol or rage, and it takes longer for them to be seen. The anger builds and builds and you can see it - just down to the simplest little thing. If you walk into the Emergency Department at nine o'clock in the morning you'll see a pile where people have swept rubbish into a spot in the middle of the floor because nobody can be bothered to sweep it up off the floor. I wouldn't do that in my house, my ward or in my rooms. I've never seen anything like it before, yet that is the environment in which people operate.

The other thing is that there is a kind of hierarchy of what is described as 'almost interesting'. There's interesting stuff, which is multiple trauma and that kind of exciting stuff, and that is classified into triage. There is good evidence that if you turn the triage system on its head and you see the non-urgent ones first you do much better in getting people through much more quickly, but they wait around for the exciting stuff and they leave the people who aren't what they deem to be exciting. They sit and wait until they either go away or something else happens. Occasionally they become very sick and then they become 'exciting'. There is a kind of ethos in emergency medicine that is different from medicine; you have to respect that because it's just who they are and the way they practise. They have a fairly short lifespan.

Ms FORREST - You are painting a picture that's very familiar.

Dr PARKES - Is it accurate, do you think?

Ms FORREST - Unfortunately it probably is. Is one way of dealing with that to have the non-exciting patients, for want of a better word, moved to a 24-hour GP clinic?

Dr PARKES - That's one way. The other thing that we are trying to do is to have this acute medical planning unit so that for acute medical patients who aren't very exciting - they are old, they've had strokes, they're complicated and they have urgent medical problems - we are trying to encourage those to be seen at a medical level. Emergency medicine is becoming almost more surgical - management of fractures, multiple trauma and so on, and people who require very intensive resuscitation.

Mrs SMITH - Is there a place for private hospitals to be encouraged to take on emergency departments, even if it's a limited type of emergency department? So you'd get one element of the community that had private cover that says, 'I think I've busted my arm, so I'll go to Calvary because it'll be quicker'. Is that an issue we should be addressing?

Dr PARKES - Yes. Firstly, private insurance doesn't pay for outpatient services. It can pay for false teeth but it can't pay for you to go to an emergency department. Again, that is a Federal structural thing and it has resisted any attempts at change.

Mrs SMITH - Is that the only reason you think the private hospitals may not have looked at some form of emergency department?

Dr PARKES - There was one here at St Vincent's; where my rooms are at the moment was the middle of the Emergency Department. The problem is that emergency departments in private hospitals invariably lose money. They attract people and in general the admission rate is about 30 per cent, so 30 per cent of people who present to the Emergency Department in a private hospital will be admitted. They therefore regard that as a marketing issue. There is talk of closing the Hobart Private Emergency Department. Calvary will probably continue because they are just so big that they can use it as a feeder network.

Mr WING - They closed St Vincent's here some years ago.

Dr PARKES - Yes. David Boadle was trying to set up an intensive care unit and I was involved for a bit with that. It ran for some time and would accept patients and look after them in St Vincent's if they came through there, but if it is going to work there needs to be some sort of funding assistance to keep the place open. The difficulty is that you have two classes of emergency patients, which further amplifies the problems that occur in the public hospital. It is a great shame that the building across from the Launceston General Hospital was not consolidated to be one big private hospital because you could almost co-locate a private and a public accident and emergency department. You could co-locate theatres, you could have done all sorts of things and there was an embryonic move to do that. Bricks and mortar are important but are only 5 to 10 per cent of the cost of a service depending on how you cut them up, so those things are possible and you could quite easily co-locate the services. Then you can start attracting, for example, interested general practitioners to do sessions. I think there are some at the General, and you could expand it in other ways.

The thing about emergency medicine is that work is supposed to be fun and most of these people just do not enjoy it.

Mr WING - Because of the pressure and lack of resources?

Dr PARKES - It is very chaotic, yet I spoke to an emergency nurse last year and she said that it is actually not, because when that sort of thing happens we know exactly what we are going to do. It is a little like intensive care work. People say it is chaotic but it is one of the most controlled environments in the hospital. The difficulty with the Emergency Department at the General is that there is a huge morale problem - for various reasons. I do not know what it is like in other hospitals but morale is not good there.

Mrs SMITH - It is interesting that size is very important for medical services and yet for accident and emergency systems to some degree the smaller they are, the better they can operate out of that hot stream. I have had several experiences with the Burnie hospital outpatients and their system is superb. Nobody goes in that door and sits for half an hour because a triage nurse does the paperwork straightaway and presumably makes the decision where you fit in the category of emergency, so at least you have been seen and had some comfort. That is a system that appears, from my observation, to work very well.

Dr PARKES - And yet that system should be at the General.

Mr WING - That is right. That sounds good.

Dr PARKES - It should be and the triage system is there. As I say, if you turn the triage system on its head and you get rid of the people who can be seen and fixed very quickly then you can reduce waiting times by a lot, but nobody seems to have taken that up.

Mrs SMITH - I think the very fact that you have been seen and some medical person has made a judgment, if you then sit for half an hour it is because you know the judgment has been made and you are prepared to wait. That does not fix the volatility of alcohol or drugs or mental health issues, though.

Dr PARKES - No, and mental health is a huge issue. I am sure you have talked and heard a lot about it.

CHAIR - Talking about alcohol and drugs, evidence has been given to this committee that the number of patients coming into the system increases every year and to a greater extent. What is the position in relation to illicit drugs in particular and alcohol? Is that an area that really is creating more difficulties within the hospital system?

Dr PARKES - From what I have read - and this is at a general level - the answer to that is yes. There is an increasing burden of drug and alcohol abuse and subsequent violence and so on. The issue is, how do you manage that and I do not think anybody has a good answer. Probably the best person to talk to is Alex Wodak, who is director of drug and alcohol at St Vincent's in Sydney. He regards it as a health rather than a punitive issue. You can lock these people up as long as you like but when they come out they do it again. I think it is harm minimisation, not only for the person but for the community in general. How you do that, I do not know. You have a background in the constabulary, haven't you? So we are looking at the same problem from different sides of the fence.

I think the difficulty with drug and alcohol issues is that there is no answer and what we are facing is a group of people for whom there is no solution.

CHAIR - Yes, it is a difficult one.

Dr PARKES - Accordingly, you have to just patch it up as best you can. You can intervene and it is a bit like treating high blood pressure or cancer. You can give someone chemotherapy if they have cancer and their hair will fall out and some of them will get better and some of them will not. We do not have a lot of interventions that work and we do not have the infrastructure to make it happen. Mental health care here is very stretched.

CHAIR - With regard to the relationship between public hospitals and private hospitals in the transferring of patients, and Mr Kirwan has been very open about that in that it has been used more and so on, is that working effectively? Can it be used better or improved, in your opinion?

Dr PARKES - Yes, it can, it is patchy. Privately insured patients bring in revenue to the hospital and so, when the hospital is empty they will do everything they can to hang onto their privately insured or entitled patients, veterans in particular. When they get busy they then decide that they will transfer these patients to the private system. As somebody who is based at St Vincent's and works in both of the campuses, I frequently get calls asking if I am happy to look after this patient and, of course, yes I am. But the difficulty is that it is such an ad hoc system. There is no consistent, streamlined system for saying these are the patients we should or should not accept. The other difficulty is the acuity, the degree of sickness of patients that can be managed there.

I have spent some time learning how to look after sick people but typically it often involves looking after them at 3 a.m. and, as I have to be at work at 8 a.m. and I did that for 20 years, I just do not want to do it anymore.

CHAIR - I am aware of a recent patient who was at the Launceston General Hospital who was in a reasonably serious situation, a mild stroke et cetera, and it was indicated to the patient at the time that there was just no bed available and that they would probably be sending the patient home. During that discussion the patient said, 'I have a gold card' and immediately the patient was moved to a bed. That goes back to the position that you raised earlier in this cost-shifting situation and its having a bearing on what is happening within the systems.

Dr PARKES - If that is true, that is appalling, isn't it?

Ms FORREST - That is not cost shifting, that is money making.

CHAIR - That is money making, and I was appalled because there was a witness there with the elderly person at the time.

Dr PARKES - There should be no excuse for that.

CHAIR - No bed available one moment and then, all of a sudden, there is a bed.

Dr PARKES - There should be no excuse for that.

CHAIR - Dr Parkes, we are running out of time. Is there anything you would like to say in conclusion?

Dr PARKES - I have said a lot more than I thought I would. I thank you for your questions. It has been very interesting and incisive.

CHAIR - It has been excellent, and I thank you very much for the way in which you have given your evidence. It has been very valuable to this committee in the findings and recommendations we will need to come up with at the end of this whole process.

Mr WING - Just for the record, would you mind stating your current role in medical practice?

Dr PARKES - I am here as the chair of the State committee of the College of Physicians. I work on a sessional basis at the Launceston General Hospital as a consultant physician and also in the diabetic centre. I work as a physician in private practice, treating people with those complex medical problems but I also have a hobby treating people with chronic pain.

CHAIR - Thank you very much, Dr Parkes, for your evidence today.

THE WITNESS WITHDREW.

Ms JANE HOLDEN, CHIEF EXECUTIVE OFFICER, NORTH WEST GENERAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR (Mr Dean) - What we thought we might do, Jane - and I don't know whether we can do this - you have the terms of reference in front of you, so I thought if we could address your submission in accordance with the terms of reference. We could, say, look at elective surgery first of all, if you're able to do that, and then we will move on to emergency department and do it in accordance with the identified terms in the document. That might be an easy way for us to go through it.

Ms HOLDEN - I am very happy to address the terms of reference and I also prepared something about what the area health service was, but that's not quite the terms of reference.

CHAIR - If you have a document there, we would appreciate it if you are able to table it.

Ms FORREST - Could I suggest, Mr Chairman, that it would be good if Jane could give us an overview of the North West Area Health Service because the north-west coast is the first area in Tasmania to initiate this. It is what is planned for the north of the State to be rolled out soon and is a way forward. I think we should hear from Jane what that is about. Even though it's not strictly in the terms of reference, it will encompass a lot of those issues.

CHAIR - I am happy to facilitate for that.

Ms HOLDEN - The purpose of creating the area health service is to integrate primary and secondary health service provision. It's really a new era in how we are looking at providing public health services in Tasmania. What we have done is created working with separate facilities and organisations and the basis of that relationship is partnership, so there isn't a dominance in any of the relationships. In the north-west that means the North West Regional Hospital; the Mersey Community Hospital; the primary health hospitals, as they were formerly known, King Island, Rosebery Health Centre, Queenstown Hospital and Smithton Hospital; primary health and community-based health services; the Rural Clinical School; General Practice North West; and other NGOs that are working in Tasmania. It is really about saying that if we pool all the resources together we could improve both the pathway for the patient and the services we provide.

The North West Area Health Service is particularly suited to that kind of model because of our health demographics, which really relate to an ageing population. It's not the oldest population, which is the north, but it is certainly ageing. We have what I call the perfect storm demographic there because we have this ageing population and a high birth rate but then stagnant growth because the middle part of the population, which tends to be low health users, are leaving the north-west. We have a relatively poor area with lower levels of formal education achieved and therefore lower incomes earned and high-risk lifestyle decisions being made. So we have a high incidence of chronic disease and poor oral health. We have some challenges in terms of national life expectancy, being lower than national and low in the State. We have a higher than average percentage of preventable chronic disease, which I think lends itself to the terms of reference, which is

really a major challenge and focus for us. There are higher than average rates of suicide, which is indicative of the population's health status and a higher than average number of children on care and protection orders, which is again the area where you start working with police, Justice, child youth and family. Those services become so important if we're going to improve population health status. I think the fundamental change from how we have worked to how we are working now is that I have been charged with not only addressing personal health goals - that is, people accessing waiting lists and people getting into departments of emergency medicine and the like - but population health gain, and that's the big ship. So now I have to have to look at what we are doing that is going to improve population health status.

We have one particularly strong asset in the north-west, the Rural Clinical School. This year 75 per cent of our intern positions at the North West Regional Hospital and next year at Mersey are held by Australian graduates, which is a really positive opportunity for us to work.

The Royal clinical schools are also working to train general practitioners so that helps us build our links between the hospitals and the general practices.

Basically what we are looking for is to make some changes from the past. We tended to work on the hub-and-spoke model and this spotlights on the spoke and you tend not to get the service, so we are looking at alternatives to that, more like partnerships where there are mutually understood obligations between resource holders and where they are going to provide the service.

We want to move away from provider-focused service provision which has been based around either the clinicians we have or the hospitals we have to look at what patients need. That sounds a pretty simple strategy to adopt and indeed it is but it is quite a quantum leap on how we looked at providing services in the past.

Whilst changing the structure isn't a panacea to the challenges we have, what we do believe is that the new environment offers fewer barriers to integration than the old environment. Anything can happen; bad things can happen in good structures and good things can happen in bad structures but what we try to do is create the best environment that we can that facilitates integration and working together.

The area health service is a local structure within the department which allows local decision making quickly where local solutions are appropriate. It allows horizontal movement of resources that are based on what the patients need. It is a structure that allows reallocation of resources to more appropriate settings and that expands resource allocation planning from personal to population health goals. In effect it is more flexible. It is not a return to regional autonomy, it is not a dependant of the department's vision mission or strategy and it is not a stand-alone authority. So we still fit very much into the model.

That is a pretty strong overview.

CHAIR - A snapshot of where you are and what you are doing. Thanks for that, Jane.

Ms FORREST - Jane, I am interested in how you see this particular model and the way it is framed impacting on the cost shifting that goes on within health. You are talking about partnerships between general practice and the hospital with the hospital providing that acute service component of the care and back to the GP. There are problems with cost shifting in that generally, so how is this overcoming that, or is it overcoming it?

Ms HOLDEN - It is not designed specifically to overcome cost shifting, it is designed to ensure the patient's treatment is delivered in the most appropriate place. We have a lot of costs incurred to the State where patients who should otherwise be seeing a general practitioner are attending departments of emergency medicine. What we are looking at is how we build the capacity in general practice or in the primary health team to get people to see who they should see for that level of care. By default we'll address some of those issues but its design is to make sure that the service that is required is delivered in the right level of care.

Ms FORREST - Do we need changes to the Medicare arrangements to facilitate that? For instance, a patient goes in for a routine cholecystectomy, the surgeon says, 'You don't need to come back and see me, yours is an uncomplicated issue, go and see your GP in a week's time', or whatever, particularly for removal of sutures. If it is done laparoscopically there is probably nothing to worry about but either way if there is follow-up needed that does not really need to be done by the surgeon because all the surgeon really needs to do is the surgery. Medicare does not facilitate that currently, does it?

Ms HOLDEN - Currently no, but there are other models as well. For instance in Devonport we have looked at wound clinics that are driven by primary health community-based nurses who are looking at that. It may be that the patient does not need to see the general practitioner either but does need sutures removed and does need someone who is competent to assess that the wound is healing and there are not any problems with that. Currently in Devonport, rather than have those people return to the general practitioners who often can't claim for that, or go to the Department of Emergency Medicine and fill that up inappropriately, we have looked at developing wound services in the community so patients can pop in on a more flexible arrangement and have those services provided. If they then need referral to general practice they can have it.

Ms FORREST - But then they fall under a Medicare item number once they go back to their GP at that time.

Ms HOLDEN - Yes.

Ms FORREST - Do you think that is adequate or does there need to be a shift in the way Medicare is arranged to enable less requirement for all surgical care, for example, to be provided under that one item number in the hospital?

Ms HOLDEN - I think that the Medicare system is complex. I come from New Zealand, which has a much more simple system. Any system creates incentives and disincentives and I think the Medicare system is quite complex in that regard. It is not particularly well aligned with the pathways but I do not see it as a barrier to us moving forward to try to address that. I could not tell you where specifically things should change to address that. Until we have done this kind of work I do not think we will know.

Ms FORREST - So you think it will become evident the further this process is rolled out?

Ms HOLDEN - I am sure it would.

Ms FORREST - Is casemix still used as a funding model?

Ms HOLDEN - We are not specifically funded on casemix but we use casemix a lot.

Ms FORREST - What reporting do you do to the Federal Government under that arrangement?

Ms HOLDEN - That reporting actually comes under Hobart, so I am not entirely sure what that is. From the Mersey's point of view, we are reporting on attendances and casemix, and the weight of those attendances as well.

Ms FORREST - The Mersey, for example, is not funded under a casemix funding model?

Ms HOLDEN - No, but we still report.

Ms FORREST - So you report under a casemix model but it is not funded under it?

Ms HOLDEN - No.

CHAIR - Jane, we will have a look at elective surgery and any issues you have there that will assist us.

Ms HOLDEN - In terms of surgical throughput, we have increased across the north-west throughout the financial year. The North West Regional Hospital has increased its total elective throughput by 17.1 per cent and the Mersey its total elective throughput by 23.4 per cent, and 38 per cent of that includes day cases. We have had a strong focus and in the submission we talked about improving access to elective surgery for residents of the north-west, and we have achieved that.

We have made some changes in our service delivery to get maximum use of the resources that we actually have. In that regard we have relocated all cataract day surgery to the Mersey Community Hospital for residents of the north-west. We have also opened an area-wide state-of-the-art endoscopy unit at the Mersey, which is another day procedure. We have brought all of the total joint replacement work from the Mersey to the North West Regional Hospital, so we have moved some of the services around to benefit the resources that are available, the skill mix that we have on the ground, and beds.

CHAIR - That has assisted you to keep up with your elective surgery commitments?

Ms HOLDEN - Even move ahead of previous obligations. Suitably we have had some additional funding via the State and Commonwealth to achieve those goals and we have used that to help us review our waiting lists. We contacted everyone on our waiting list to make sure they are waiting and what their expectations are in that regard. We work very closely with the clinicians to identify where services should go, how we should

manage waiting lists and what opportunities they see. In some services we are moving now to have a pooled waiting list so that any surgeon that has fewer patients can actually draw patients from that pool and offer them surgery sooner than if they were waiting with someone else. We have taken quite a number of steps to reduce that challenge.

We have not yet opened the fourth theatre at the North West Regional Hospital but we have the funding to do that and we hope it will be opened by about October this year. We have achieved those gains within the current resource, so they are really productivity gains. The purpose of the fourth theatre is to allow us to provide acute surgery, unplanned surgery during business hours, which is a safer model.

Ms FORREST - Is that fourth theatre to be established as an emergency theatre? Is it staffed or will it be used?

Ms HOLDEN - We use the theatre but the capacity of the fourth theatre allows us to use any one of the four for acute emergency work. So we shuffle all of it.

Ms FORREST - Obviously it requires increasing staffing levels for the fourth theatre. Does it also mean that you have to have increased staffing levels to cater for that emergency or would the team in theatre 1, for example, be the team that does the emergency surgery?

Ms HOLDEN - It depends what the surgery is. It could the orthopaedics, general surgery, gynaecological - it depends on what the emergency is. But we have consultants on call in each of those disciplines and that is the team we would expect to be responding to the emergency.

Ms FORREST - As far as your theatre staff is concerned, though, theatre nurses?

Ms HOLDEN - We have a budget that copes with that growth.

Ms FORREST - So you have adequate staff to facilitate that?

Ms HOLDEN - We are currently recruiting. We do not need them on board just yet because we are not ready to open the theatre, but we have been working towards that.

Ms FORREST - So the extra State and Federal funding you referred to enabled you to undertake some of these increases in output?

Ms HOLDEN - Yes.

Ms FORREST - That was provided to all hospitals, though; it was not just the North West Regional Hospital?

Ms HOLDEN - No.

Mrs SMITH - Jane, you mentioned that all the cataract day surgery is going to the Mersey, all the orthopaedics are going to Burnie - shades of some of the Richardson report. Has it been well accepted by the community, considering the politics of what went on when the community were trying to be convinced before that you get a better facility by doing exactly what you are doing? Has there been any backlash?

Ms HOLDEN - No, there has not. I have taken into account the history and it would be stupid of me not to have. I felt one thing I could do that was different was really work on this issue of partnership - what you do and what we do and how that is going to be linked. In addressing what was perceived as the previous dominance of the North West Regional Hospital and the subservience of Mersey, I think that message infiltrated and people were very fearful.

The other thing I have done is put resources into Mersey rather than taking anything away. Although the major joint replacement surgery is being done at Burnie, we still do minor orthopaedic work at Mersey. Although, most of the very major general surgery is being done at Burnie, we are now bringing both Mersey general surgeons across to Burnie to do that work. So we are offering a rotation so that skills and interest is maintained and people feel that what they are doing is valuable. Similarly with nurses, where nurses who previously were very interested in eye surgery now do not get access to cataracts at the North West Regional Hospital. They can in fact go and work at the Mersey as well to keep those skills updated. So we are taking, in principle, the same approach, which is a very sensible approach but tried to address those issues that were seen as disadvantaging one or the other institution, particularly the Mersey Community Hospital.

Just for your interest, I had an e-mail only last week from the surgical ward, the day unit and the theatre and all those nurse unit managers saying they had one of the most exciting follow-on days in a very long time and how fantastic it was. In fact, I think the Mersey Community Hospital's morale is pretty high.

CHAIR - It is good to see that the hospital is coping well with elective surgery.

Ms FORREST - Admittedly, Jane, this was what was suggested in the health plan. It was the way it was trying to be implemented. This particular thing we are talking about really only is an issue for the north-west coast because at Launceston you have one hospital and at Hobart you have one hospital. So applying a similar concept to there can deal with things that flow through but you cannot shift half your services around.

Is there a move then to look at some of the other services the Mersey is providing, and similarly at Burnie, in that they might fit better - high-risk obstetrics, for example. I am aware of a recent report of Saunders and Douce that says that certainly the higher risk would be in Burnie where you have the ICU and the back-up and allow your low-risk birthing to continue at the Mersey.

Ms HOLDEN - Yes, that is an active document that is out for final discussion and fits within the framework of the Tasmanian Health Plan and the Clinical Services Plan and also emphasises the need to promote the Mersey level of service to local women and for Mersey obstetric service to think more broadly and offer other options which provide more continuous care that women are choosing these days - caseload and those sorts of things. That is exactly where Mersey is looking now. My expectation from that will be not what I think was previously felt for, in their minds, no good reason high-risk patients would go to Burnie, but there is something very unique going on at Mersey that local women can access. Other women may choose to go to a caseload kind of model and Mersey would be the obvious choice for that.

Ms FORREST - Currently a lot of women come from the Mersey area to Burnie to access that service - no-risk women, that is.

Ms HOLDEN - Yes, and partly that's around us getting out and really promoting what is being offered; partly it's that the North West Private Hospital, which is still a public obstetric service, is quite aggressive in its marketing but also they offer a Know Your Midwife Scheme. It is really an opportunity for Mersey to look at itself and say, 'We're on a new path'. I just met with the senior nurses from the obstetric ward yesterday and they are working on exactly that path. This is a great opportunity to reposition themselves and offer a contemporary service.

Mrs SMITH - Is there still a need, do you believe, considering the way you worked before, for the State still to be paying for that public service within the private hospital in the Burnie area?

Ms HOLDEN - I'm not sure what you mean by 'need'?

Mrs SMITH - Initially my presumption was that all births went to the private hospital and the State was paying an amount of money to the private hospital to deliver that service.

Ms HOLDEN - There is a contract for service that is a legally-binding contract that the State entered into in 1993 and that service is subcontracted to the private hospital to provide but it remains a public service in that regard. I would chair its meeting to discuss service plans and things such as that. Increasingly, the North West Area Health Service is taking a leadership role in that. I have quite a few negotiations with the CEO about the finances and the detail of the contract, but the strategic issues belong to the State as the funder of that service and through this review we are taking that role more clearly, I think.

Mrs SMITH - So you're comfortable with that situation as it is at the moment?

Ms FORREST - If we could build an obstetric wing onto the public hospital up there, would that be a better outcome? Is that what you're asking, Sue?

Mrs SMITH - Yes. All of these things cost money. Can the private system deliver better to the public patients or would we be better placed financially if it was provided for within the walls of the service of the public system? It appears there is great input from your area anyway.

Ms HOLDEN - At a strategic level. I don't think that the service is better provided by private and I don't think there's any evidence that it is a worse provision in terms of client/patient outcomes at all. All I would say is that I would think in most circumstances obstetrics is a fundamental public service and would normally fit in a model with other publicly-funded and provided services. It's a unique arrangement but one that we are working hard to make work.

CHAIR - There being no further questions on that term of reference, can we go into the Emergency Department side, Jane?

Ms HOLDEN - The growth of the Emergency Department at the North West is relatively static over the years, although it has increased quite significantly since - and I do not know how far you want to go back. For instance, if we go back to 2005 we received about 22 000, this year we have seen 25 000 and what is interesting is that that relatively minor growth is across all of the categories and in particular category 1 and that is because we bypassed the Mersey Community Hospital in category 1 so those patients come to Burnie to the North West Regional Hospital. At the Mersey there was a growth of about 1 200 additional patients in the last 12 months. Some growth was in category 2 but the majority of the growth is in category 5 patients who could be seen in a primary health setting, so that is a growth that we are very interested in to try to look at alternative pathways for patients.

CHAIR - The obvious question there is why that is occurring.

Ms HOLDEN - The issue around that is that we have challenges in accessing general practice across the north-west during office hours. There is a view that it is after hours but in actual fact when we say 'office hours' I'm thinking about an evening finishing around seven o'clock or eight o'clock. It is certainly not opening something else up to midnight. Most of the category 5 and some category 4 patients we are seeing are presenting during office hours.

CHAIR - On the growth in this area in the Emergency Department, I think that is contrary to the trends here in the south of the State from the information I have, and Ruth might have more. Trending up was quite high for admissions through the emergency departments. Why is there that difference between these areas, the north and south and the north-west?

Ms HOLDEN - It may be the base from which we are starting. I know that that pressure was there but, on our numbers, every other person on the north-west goes to an emergency department every year. I doubt that that has been historically the situation in the north or the south. Emergency departments, particularly in the Mersey area, have been seen as an alternative to general practice and that is what we have to try to address. Although I can't compare that, it may be that the difficulty accessing general practice is presenting similar issues. Our populations are ageing and chronic disease is a major issue for us; as patients with chronic disease get older they get more complex and departments of emergency medicine are often where they are sent.

We have introduced a couple of initiatives in the north-west which have included offering what we call the 'hot physician' -

Ms FORREST - It sounds good to me.

Laughter.

Ms HOLDEN - the physician that is on call being directly accessible to the general practitioner because it is the case that GPs have limited access to consultant advice other than via a department of emergency medicine. They can refer for an outpatient booking but that could be in a week or perhaps two and they really want someone to give their patient a look today because they are just wondering whether they are right with this medicine, whether things are right. Quite often we know when we have tracked pathways that for a number of our patients if they had seen the physician on the day they

were referred to the Department of Emergency Medicine they may well not have required admission. I think that view is replicated in the north's approach with the Medical Assessment Unit. Internationally we are all coping with chronic disease and physicians right at the front door are very powerful deterrents to presentations to emergency departments and, in fact, unnecessary admissions.

CHAIR - Are there any further questions on this part?

Ms FORREST - With the hot position, effectively the GP, if they send a patient in who has seen them in their rooms, they will go to that position rather than have to go through the process?

Ms HOLDEN - Call them directly.

Ms FORREST - Yes, that is right. So it is basically circumventing a wait for that patient and also immediate access, pretty much, for the GP who would normally have to send a patient in and go through an often frustrating process.

Ms HOLDEN - Absolutely. As soon as the patient comes with a letter or a facsimile to the Department of Emergency Medicine, they are seen by the junior, then the registrar, then referred to medicine and may not in fact see the physician until the next day.

Ms FORREST - So circumventing all of that?

Ms HOLDEN - Yes. When you look at pathways that is the sensible place to start.

Ms FORREST - Is that being implemented anywhere else in the State?

Ms HOLDEN - No, and we are just launching it now.

Ms FORREST - So you have a pilot on it?

Ms HOLDEN - Yes.

Ms FORREST - It will be interesting to get feedback.

Ms HOLDEN - Yes.

Ms FORREST - How will feedback on that project be reported?

Ms HOLDEN - The preparation around it is identifying a group of patients who spend their lives, sadly, going in and out of hospital. It is a nightmare for them, so we have that group of patients identified and we would be looking at admission rates for that group relative to previous admission rates because that is the group we are interested in. As well it will be general practice satisfaction, how accessible was it, and physician satisfaction. It is driving them crazy; they really need to look at that as well.

Ms FORREST - There has obviously been awareness raising with the GPs in the area?

Ms HOLDEN - Yes we will and, of course, relatively loudly. We have to introduce it in a sensible way as well. Once people get confidence in the service it will be something. I write to general practice every quarter and we will be letting them know that is what we are doing.

Ms FORREST - With the mental health patients coming into the Department of Emergency Medicine, it has been identified at the LGH and the Royal Hobart as being an issue of significant concern at times, so how it is dealt with at the North West Regional?

Ms HOLDEN - They are challenging patients to manage. What we are doing is working very closely with the Mental Health Service to address concerns. The mental hospitals have tentatively launched a CAT team, an acute response team, who can be called to the Emergency Department to assist a patient quickly and then facilitate a transfer into Spencer Ward if that is what is required. That seems to be improving the situation.

Ms FORREST - Is it a 24-hour-a-day service?

Ms HOLDEN - Yes, it is. It is an after-hours service because for the rest of the time they have a registrar around or we have a psychiatric nurse who works with our DEM, so we have some good liaison. We have extended that relationship to include the Mersey Community Hospital because that is a challenge and they have to transport those patients as well.

The challenge also in the Department of Emergency Medicine at the North West Regional Hospital is that we do not have anywhere safe for them to go, so patients who are particularly disturbed can be very disruptive in an open sitting in that regard. So we are looking at working to redesign that environment so that we have a safe environment for those patients.

Ongoing education to all staff, including medical staff in the Emergency Department, about de-escalation can be a really powerful tool as well.

Ms FORREST - Do you have a problem with bed blockage, getting patients out of your DEM who need admission, and what do they relate to?

Ms HOLDEN - Yes, we do at times. We do not have quite the same pressure that Launceston has. Some of that is related to the other end - patients being discharged out of the medical ward, for instance, to a suitable facility or home or those sorts of things. We have introduced a multidisciplinary discharge planning meeting twice a week and that has really picked up the focus on moving people through. We have also adopted some of the lessons learnt from the trip to England where we looked at identifying the discharge date on admission so that there is an expectation of everybody, including the family, that their relative will be discharged on Thursday and not the following Monday, so we need to get things organised.

We also have weekly reports on ACAT assessment and bed status of nursing homes in the north-west. I meet with those providers to talk about opportunities we have to get patients more quickly through the process. We are getting our 10 transition beds in December, and funding which will facilitate some of that movement. We have ACAT

sorted pretty well now. The challenge is, once assessed, getting people into the nursing homes. That gap is one that we are still addressing.

Ms FORREST - So clearly the north-west coast does not have a problem with no aged-care beds available.

Ms HOLDEN - No.

Ms FORREST - What is the problem there?

Ms HOLDEN - It is a discussion for our next community forum. There are a couple of things. One is that our policy is that we say you are now going to need nursing home support. You can select three nursing homes and you will go to the first of those three that comes up. But around the Ulverstone and Penguin area, those three do not come up very often. So one of the options is to change that policy. After waiting a reasonable amount of time - and that needs to be decided - you take the first available bed and we still hold out for the one that you want. But that is not acceptable to the nursing homes because of the complexity of work they have to do for what is considered a short term. So one of the debates that no doubt we will have at the network meeting is that if a week is too short and six months is too long, what is a reasonable time you might have a patient for that would make it reasonable for you to accept someone while they waited for where they needed to go, rather than close beds. So we have an interesting issue in the north-west.

Ms FORREST - Are there funding issues around that too, Jane? Do the nursing homes get funded adequately for short-term stays under that arrangement?

Ms HOLDEN - I am not au fait on that. But in the meeting I had, just to try to set some ground rules for the meeting we are having, my impression was that it was not worth their while financially. There is also the disruption of a new resident for everybody else who lives there, if it was a short stay. That was my impression but they would be the ones who would know that.

Mrs SMITH - The short stay might be six months.

Ms HOLDEN - It may well be six months.

Mrs SMITH - Because if they choose Penguin but it is very tight, they may be in Wynyard for six months until their choice comes up.

Ms HOLDEN - Yes. One, in fact, agreed to go somewhere else and then said, 'No, this is where I will stay'. So those things will happen.

Ms FORREST - Anecdotally we hear of that happening more than once.

Ms HOLDEN - It will be a really interesting evening as these facts get put on the table and have some challenges for us to address.

CHAIR - What is the answer to this? Greater availability of beds and more homes and greater funding?

Ms HOLDEN - It would be addressing whatever is seen as the financial barrier by the nursing homes to take short-term residents. It is quite a lot of work, I understand, for them to do all of the assessments and submit all of the necessary papers to get the appropriate funding for this resident, only to find, in a matter of weeks, they are gone and all that work has gone to nothing.

Mrs SMITH - If the funding is attached to the resident, when the resident moves from home A to home B you would think they could transfer -

Ms HOLDEN - I don't know the detail enough around that and I have only just learnt about it. The truth is that it's not simple.

CHAIR - I think that is the reason for my question: what changes need to be made?

Ms FORREST - We need to talk to the aged-care providers to get that information.

CHAIR - Absolutely. I am just wondering from Jane's point of view, whether she had an idea.

Ms HOLDEN - Transition packages are an option, where we could pay the nursing home an agreed fee per day and they wouldn't have to go through that other process. The only other thing I can think of is some of the complexity around respite. The patient would have to go home before they would be eligible for that, which doesn't make any sense either. The issue is really to do with the aged-care providers. What I see is empty beds and demand, and they're not well matched.

CHAIR - An aged-care provider problem which impacts negatively on you and the system.

Ms HOLDEN - Yes.

Ms FORREST - There's no lack of beds on the north-west coast. It's different in Launceston.

Ms HOLDEN - Yes, although I think the north would argue there are similar issues.

Ms FORREST - There probably are as well, in addition to the lack of beds. That needs changing.

Ms HOLDEN - In terms of that other issue, they are some of the reasons for blockage. Other reasons for blockage have been around the right mix of surgery being provided in the right place and that is assisting some of the flow as well through both departments of emergency medicine. I think that is something we have identified. Where there are limits in bed numbers - paediatrics, this flu season, and things such as that - we need to cope with those. They are unusual events that we're there for.

CHAIR - Jane, do you have any comments in relation to 4?

Ms HOLDEN - I have some data but I have made some assumptions in getting that data, and I just wanted to be really clear about that. If the total number of full-time equivalents at

the North West Regional Hospital is 519.67 - I have used an assumption that under a band called 'Health and Human Services', which is a big group of staff, if I look across the State and split those, 50 per cent clinical and 50 per cent administration, I have applied that because they do include health assistants and people who are providing the direct care - roughly 409 of that 519 are providing clinical care, which is the kind of percentage you would basically expect, an 80:20 kind of split, at the North West Regional Hospital. In terms of cost, it is slightly different and that is about how the North West Regional Hospital is designed. You would normally see in a hospital a 70-80:20-30 split staff to every other cost, but at the North West it is a 60 per cent salaries and wages split. That is around subcontracted services, ownership issues and those sorts of things, so we have a non-salary base there that is different from anyone else's in that regard.

Mrs SMITH - You're delivering services across the entire area. Do you have administrative staff in both Burnie and Mersey?

Ms HOLDEN - Yes.

Mrs SMITH - Has anyone looked at economies of scale? Administrative staff can direct the traffic from one central point. Has that been looked at to see if there is any advantage?

Ms HOLDEN - Yes, I have looked at that. We have some obligations under the heads of agreement with the Commonwealth around who needs to be based at the Mersey Community Hospital, so that has some impact on that. For instance, I have a personal assistant who travels where I travel, between Burnie or Mersey, and I do go to both every week. We have a director of medical services and those resources also move around the area. Similarly, in nursing we have the same sort of arrangement. I think there is a slight view from my colleagues that I'm a bit light on administrative/clerical support at the moment, but I'm not convinced.

Mrs SMITH - You said you are required under a heads of agreement - is this the Commonwealth-Mersey agreement?

Ms HOLDEN - Yes.

Mrs SMITH - And you believe there could be some cost savings if that agreement was more flexible, or better managed perhaps?

Ms HOLDEN - It's not inflexible but I have asked for a change to that agreement to allow some flexibility with the general manager that I think would facilitate services better across the area. It isn't a show stopper if that's not acceptable to the Commonwealth but I think that would be an opportunity. That's really the only position that requires them to be full-time only at Mersey. The others give some flexibility and I have used that and the Commonwealth has been supportive of that.

Ms FORREST - So when that agreement expires, which is next year -

Ms HOLDEN - It started last year, so it is 2011.

Ms FORREST - It is a little way off, but when that expires is that an issue that you would work on so far as sharing of administrative non-direct-patient contact staff is concerned?

Ms HOLDEN - The whole deal is critical, but I'm sure I would be asked if I thought there were any things that would functionally improve it.

CHAIR - Can we go on to point 5, work force planning strategy?

Ms HOLDEN - We work in a highly-competitive sector for recruiting staff and there really isn't any area, including management and Human Resources, where we aren't competing for very good people across the country and internationally. We have taken an approach of looking at population health need and then asking, 'Have we got the right resources in that regard?'. Medicine was one area of particular concern to us on the north-west, getting the right sorts of physicians with the right kinds of interests to address our concerns, and endocrinology for diabetes has been a major one. We are really looking for generalists as well, increasingly. That's what we are after, people who can respond as a general physician rather than only as a specialist in an area. We have looked at that and we have been quite successful in our recruitment. Largely that has been around everybody who knows anybody shoulder tapping them a lot. It's been around the fact that we are promoting in our recruitment the beauty of where we live and work and the work-lifestyle balance that is achievable in the north-west.

Ms FORREST - As shown on *Australian Story* a couple of weeks ago.

Ms HOLDEN - Yes. That is a really good example of getting locums where we have needed to fill gaps in our rosters and then talking to them quite seriously about opportunities to stay. We have recruited three on that basis.

CHAIR - Is there enough autonomy given to you in recruitment in the north-west region?

Ms HOLDEN - Yes, I do have the autonomy to recruit. The processes of getting the job on the system are long.

CHAIR - How can that be changed?

Ms HOLDEN - I think the intent of the processes being long is about looking at control in that very expensive chunk of where we spend taxpayer dollars.

CHAIR - This has come up before in this committee, that the filling of positions and vacancies and so on is drawn out, cumbersome and not friendly at all.

Mrs SMITH - You can lose them before you get through the paperwork.

Ms HOLDEN - I think it is a cumbersome process and I have raised those issues. I think there is some merit in the control aspects of the process because I think you can spend a lot of money very quickly on people if there are not controls. This is where the autonomy I have enables me to actually going to target that person, that is the one we want and if I have to catch up with that process I will quickly go and make that process catch up. You do not need to break the rules but you need to be proactive.

Ms FORREST - Flexibly apply the rules.

Ms HOLDEN - Yes. I have not lost anyone because of the rules, I might have been frustrated because of the rules but I have not actually lost anyone in that regard. I think work has been done, certainly on the devolution of the human resource service. I will have on the north-west for the first time since I began there in December 2007, a team of HR people who are actually focused on working to recruit and support the north-west rather than being from Launceston or Hobart which, despite everyone's best efforts, has not been as responsible as it should be.

Mrs SMITH - Has the Rural Clinical School assisted?

Ms HOLDEN - Certainly, there is no doubt. I don't think we would have got Michael Buist, for instance, if we were not able to also offer him something that satisfied his academic career desires. Most clinicians want to teach, that is part of the professionalism side of it, and I think that the Rural Clinical School is a powerful ally and partner in that regard. There are a number of conjugant positions as well.

Mrs SMITH - Does the north-west have any significant vacancies at the moment?

Ms HOLDEN - We still have some vacancies amongst the specialist emergency doctors in Mersey and I think we have one in Burnie. We are offering a position right now to an endocrinologist that will address a long-term problem that we have had. The turnover of nursing staff is quite high and we are always recruiting senior experienced nurses and competitively doing that within the State, and nationally and internationally for that matter. I do not think there is anything that is screaming out as quite the same sort of problems we have had in the past two years. We are starting to find that we are getting some traction on those and of course the more that you have in a team, the more attractive the team is to newcomers. Nobody wants to work a one and two roster but you start looking at a one in four and people say that they can live with that.

CHAIR - An issue has been raised in relation to the correct payment to nurses in relation to days off, double time, et cetera. What is the impact on you in your area of that?

Ms HOLDEN - I only saw that information late last week and I have not done any of the sums in regard to that but I am nervous, I think it would be fair to say, about the potential impact of that financially.

CHAIR - It will have to come from your current budgets and so on?

Ms HOLDEN - I would imagine, yes.

Ms FORREST - I think the Treasurer would say that anyway.

CHAIR - I think the Treasurer will certainly say that. Perhaps the next lot of witnesses might want to comment on that.

Ms FORREST - With regard to the palliative care specialist nurse, there is a position that is funded for the north-west area and Rob Brogan is trying to force the issue, I understand.

This is an area where we really need to have a senior specialist nurse or we are not going to keep what we have.

Ms HOLDEN - I think we have been pretty proactive in this regard. We have found within the two hospitals some additional resource to make that position a one FTE so there are, in addition in effect, two potential roles here. I am working with the palliative team to try to look at the statewide team, to try to look at models that will support the north-west having a service and there are two views on the table. One is that you need a ward or a place or beds particularly for them, and the other is the model that we tended to go down, which is I think called 'a hospital without walls'. What it is really saying is that we utilise resources that are available within the community to support palliative care patients. I think the answer will be a balance of somewhere between both models. A lot of people do like to die close to home. Some are increasingly finding it far less fearful to have someone die at home than they thought it would be if they are well supported in that regard. Given our geography, it is going to be hard if we have just a single place for patients to die. If you happen to live in Zeehan, that is really a huge burden for people and maybe somewhere closer to the family would be a better solution. So we are likely to look for a mix. Once we have the model, the right people and room, we will get clarity around who is going to commit to the service. But there is so much vagueness that the first question is: what are we talking about? The second is probably how we are going to achieve that. At this stage we have supported a general practitioner to go and do the training. She is based in Deloraine, as I understand it, but has made a commitment to look at the north-west to help support the north-west. She is doing a diploma.

Ms FORREST - It takes six months, doesn't it?

Ms HOLDEN - No, a year. There are two components of six months each. So that is our strategy at the moment and also to get the plan moved through.

Ms FORREST - Do you think that sort of care should be where the funding follows the patient, so if the patient is going to be dying at home in Zeehan, that support and funding goes to the patient, to the person, rather than being linked to a particular bed in a hospital, for example?

Ms HOLDEN - I do not think either of those models, either linking it to a bed or linking it to a patient, are going to work in that regard. We are going to have to find a model that is flexible. The palliative nursing service in the north-west is really a strength in that regard and it will be in the future as well. We are likely to see a model that develops the skills that they have been learning throughout the north-west to up-skill people in the community.

CHAIR - If you were able to identify any barriers to productivity and delivery of services within the North West Regional Hospital, what would you say? Are there any barriers? You referred to one about moving patients out of the hospitals.

Ms HOLDEN - I think it is true to say that the structure of the hospital has some limiting factors on our productivity, and that we do not own that facility, so investing is a challenge for us. It has not stopped us investing but those little changes are, in fact, investments that are accrued to the owner. So I think the structure is one that is a

challenge in that regard. I am not sure that there is any evidence that has challenged productivity. There are lots of perceived areas but I have not really come across any that have been show-stoppers so far.

CHAIR - Moving to term of reference 6, are there any issues there, Jane, that we have not previously covered?

Ms HOLDEN - No, I think we have probably covered them.

CHAIR - Jane, thank you very much for coming down from the north-west coast today.

THE WITNESS WITHDREW.

Ms NEROLI ELLIS, ANF TASMANIAN BRANCH SECRETARY, **Ms SUSI FREEMAN**, ICU NURSE, LAUNCESTON GENERAL HOSPITAL, **Ms DIANA MORRISON**, REGISTERED NURSE, EMERGENCY DEPARTMENT, LAUNCESTON GENERAL HOSPITAL, AND **Mr STUART FOOTE**, ANF NORTHERN ORGANISER, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Dean) - Thank you very much for your submission. Members would have read it through and have a reasonable understanding of it. What I will do now is leave it open to you to make any comment you want and no doubt we will have a lot of questions as we go through. Neroli, I will leave it to you.

Ms ELLIS - Good afternoon and thank you for the opportunity to address the committee. Obviously nurses make up over half the work force of public hospitals so we have a fairly significant input into the future of hospitals.

Nurses have put quite a few submissions forward to the Government in the past along the lines of elective surgery submissions, the Royal Hobart Hospital solutions paper and cost savings for the current financial situation, but unfortunately many of those recommendations have not been put into place and that is very disappointing when nurses put a lot of time into providing those solutions. So hopefully some of the solutions that we are providing for you today may have some legs.

We want to firstly acknowledge there have been significant improvements in the management of the public hospital since we did the submission. There has been a clear change in leadership, particularly at the three hospitals, with the Royal Hobart Hospital with its acting CEO, Michael Pervan, and the Executive Director of Nursing there, Susan Price. We certainly have a much more open relationship and much more collaborative approach to moving the partnership forward, particularly at the Launceston General Hospital with John Kirwan and at the North West Regional Hospital with Jane and our executive director now.

CHAIR - Those things tend to happen when submissions are put in.

Ms ELLIS - Maybe we should do more of them then. No, I think it was happening before then.

Mr WING - It's not happening in road safety.

Ms ELLIS - The area of health service integration will provide challenges going into the future but the ANF is fully supportive of that to ensure that continual care is the best option. We were a bit concerned when the Federal Government put forward the proposal of using the funding between primary and public hospitals. We see that as being a real disincentive and again, we would be concerned about going back into that separation, that from a Federal perspective.

I want to touch on the Tasmanian Health Plan as in where we are and where we need to be. In eight years we need to have another 345 additional in-patient beds. Dr Heather Bellington is saying this is what is predicted on our -

Mr WING - Statewide?

Ms ELLIS - Statewide, 345 additional in-patient beds. That is just in-patient beds, plus another 67 day-case beds. This is out of the Tasmanian Health Plan report. In addition to that, there's an additional 25 000 ED presentations expected across the State, so you can see that capacity is going to be a major issue. Capacity is already an issue now and the prediction on the demography is going to ensure that that capacity is going to continue to be pushed.

For us, from a nursing perspective, we have a system of safe staffing and benchmarking where we can look at a ward and say, 'Of this ward of acute medical patients, how many nurses do we need to safely staff it?'. It is a benchmarking system called the nursing hours per patient day. It is embedded in our industrial tools, our enterprise agreement, and it needs to be there so that we can't be driven by budget but by safe staffing and safe patient care. We are a bit concerned that funding and capacity is really starting to impact now on hospitals. I will table a couple of additional reports to give you an example. One is a review of benchmarking of the medical ward at the Launceston General Hospital and was done in response to workload grievances. When you're doing double shifts on a regular basis, you don't feel you can take meal breaks, but nurses were raising the issue of not having safe staffing. That has identified another 11 full-time equivalent nurses needed to be safely benchmarked.

CHAIR - That's here?

Ms ELLIS - Yes, that's here at the LGH, on the medical ward. In Ward 5B, the orthopaedic ward, another six full-time equivalents need to be put in place for safe staffing. The intensive care unit at the LGH, which has been benchmarked but not acted upon, needs another 14 full-time equivalents. These are just snapshots of the required additional staffing. Of course that is absolutely impossible for the CEOs to try to manage that within the existing budget. It is about acute emergency care and intensive care is not something you can often control but we don't really have any capacity for elective ICU.

Ms FREEMAN - Elective surgery is being cancelled on a regular basis because we don't have beds. Since May we've only put in a couple of patients from elective surgery. For six months we have been running the intensive care -

CHAIR - Just so we understand, you said there were only a couple of patients -

Ms FREEMAN - From elective surgery who required ICU have been done. There were no patients going for elective surgery to ICU since May until last week.

Ms FORREST - Just to clarify things for members, sometimes patients are booked in for elective surgery - say they are going in for a hip replacement - and you know they're going to need intensive care afterwards so you don't start the procedure until you know there is a bed available.

Ms FREEMAN - So these patients are being cancelled and cancelled.

Ms ELLIS - Only emergencies are coming in. They still have their full capacity; they are full but we don't have enough ICU beds.

Ms FORREST - They still do other surgery that doesn't require ICU, but if someone had a reaction to the anaesthetic drugs then you're in trouble.

Ms FREEMAN - For the last six months the ICU has been running on the goodwill of the nursing staff with overtime, double shifts and part-timers working extra shifts to staff the ward. We do not have trained casual staff available for ICU; we only have about three people in the north who can work in ICU, so it means we are regularly working 15-hour and 18-hour shifts.

CHAIR - What sort of assessment is done on the health issues of nurses working those long double shifts and so on? Are there any risk assessments done on that?

Ms FREEMAN - There's none.

Ms ELLIS - There's plenty of research around showing that working 17 hours straight or a double shift is equivalent to drink driving of 0.07, I think, so the effects of driving home or of patient care is really quite significant. Obviously the nurse manager there has been really supportive but the issue is that they are 14 staff down. They can't just put in the extra staff because they don't have the funded positions. They have been working to absolute capacity and are being required to work double shifts to cope with the current load.

Ms FREEMAN - And often up to four staff can be working a double shift at one time, which really does put our patients and staff at risk of litigation if they do something wrong.

Mr WING - As well as the health of the nurses.

Ms FREEMAN - Yes, and that leads to more sick leave because people do a couple of double shifts in a week and then two days later they get sick so there is that problem and that has been ongoing. It has been a problem on and off since 2005 when we were benchmarked, but the last six months it has been continuing without any breaks whereas before we would have a quiet period of time whereas we have been doing double shifts now for six months.

Mr WING - Why is that?

Ms FREEMAN - Because we do not have enough positions.

Mr WING - Why has it been greater in the last six months?

Ms FREEMAN - The hospital is busier and the ICU is busier. We are funded for five ventilator beds plus we have primary care beds but we are frequently ventilating up to eight patients, which means that is all one-to-one nursing.

Mr WING - Is there any particular reason it has become busier in the last six months?

Ms FREEMAN - It's an ageing population and an unhealthy population, I think.

Ms ELLIS - The Royal impacts there as well - the Royal's intensive care beds. The hospital has been running at about 105 to 110 per cent capacity so there is no room to move; there is no flexibility there. Sometimes previously you could bypass and patients would go directly to ICU in Hobart but the Royal Hobart Hospital's ICU is filled absolutely to capacity and there is nowhere to go.

Ms FREEMAN - There is nowhere to bypass now. Often we are asking for beds in Melbourne and places and we cannot get people out because they are always full too.

Mrs SMITH - So if we have the current nursing staff doing six months or more at double time the cost must be the same. Has there been any work done -

Ms FREEMAN - There has.

Mrs SMITH - on saying you are doing double time, two of you will do single time each? Surely the costs must be very similar. Has there been a study done of that?

Ms ELLIS - The budget Estimates from last financial year for overtime nursing has escalated. I have don't have the figures for ICU breakdown. The LGH figure for the year was $230 000 for overtime for nursing -

Mr WING - That is penalty rates too?

Ms ELLIS - Yes.

Mr WING - So it would be cheaper to have nurses working normal hours with no penalty rates.

Ms ELLIS - We all know that.

CHAIR - You know it but perhaps DHHS might not know it.

Ms ELLIS - The CEOs have been caught really because when we first brought in the system to benchmark across the State we benchmarked all the general medical surgical wards and Treasury put that money in for the extra 110 FTEs who were required. Then that was cut off and any more benchmarking that would be done would have to be done within existing funding or existing resources so the issue is now that beds are closed. Beds have been closed because they cannot afford to put in extra nurses to open up those beds. So that, again, is about capacity. Or the elective surgery cannot be undertaken for emergencies because of economies et cetera because they cannot get them in.

Ms FREEMAN - They are full all the time.

Ms ELLIS - We have raised that with David Roberts, the secretary of the department, and he has given a commitment to do a review of the intensive care beds across the State because when you look at national benchmarking we are below capacity because our private sector does not have the ICU capacity that other privates do in the other States. Our private is really just HDS.

Mrs SMITH - It does not matter how many reviews David Roberts does, unless there is more money out of Treasury the pie is the same and something else suffers. We have bed closures and staff working exceptionally long hours because of a lack of finance to fund that further.

Ms ELLIS - There is a whole range of things that I would like to go through, some of those other initiatives that could be used for cost-saving purposes. The bottom line is we have theatre suites across the State closing. So we have a theatre suite at North West, a theatre suite at Launceston General and two theatre suites at the Royal closed because we do not have enough funding for the extra nurses.

Mrs SMITH - In your submission your statistics show that we could train plenty of nursing staff if we had the funds. The issue is not the lack of nurses, it is the lack of funds.

Ms ELLIS - It is unfunded positions.

In neonatal intensive care at the Royal we do not have any beds closed but we have about 15 vacancies there. The funding is there but we do not have those specialised nurses there for neonatal intensive care but that is a specialist area for the Royal Hobart Hospital, an area of special needs.

Mr WING - How is it that you are able to get, say, $230 000 extra to pay overtime at penalty rates and not get an equivalent amount to engage more nurses?

Ms ELLIS - $230 000 would not fund 14 extra nurses, there is no doubt about that.

Mr WING - It would fund some.

Ms ELLIS - It would fund some but clearly the bottom line is that if you had the extra 14 nurses you would actually have better professional development, better succession planning as far as getting some more junior nurses there to train them up and make sure that they were comfortable so it is about sustainability.

Ms FORREST - A better quality of life.

Ms ELLIS - Of course, a bit of home life.

Mr WING - How many more trained nurses would $230 000 fund?

Ms ELLIS - In total cost, three.

Mr WING - As low as that?

Ms ELLIS - Yes.

Ms FORREST - When you consider all the oncosts.

Ms ELLIS - It is the oncosts, the penalty rates, et cetera.

Mr WING - Administrators would see it more beneficial from their point of view -

Ms ELLIS - More cost-effective.

Mr WING - more cost-effective to have overtime.

Ms FORREST - We need to factor some of the sick leave into that equation as well.

Ms ELLIS - And the workers compensation and all the other issues.

CHAIR - Is another outcome of this nurses moving on? I think it was mentioned that nurses tend to move on.

Ms FORREST - Into Parliament and places like that.

Laughter.

CHAIR - Is that another outcome of the pressure that is put on nurses to produce?

Ms FREEMAN - I do not think in our area that is the major problem, I think the problem is that because we do not have the positions we cannot attract the staff. Last year I had people come and knock on the door from the mainland. They wanted to come and work with us, trained intensive care nurses, but they could not be offered a permanent position so they will not come to the State. They will not come for a three-month contract because they need to borrow money for houses and things and -

Ms FORREST - The bank will not give them a loan if they don't have permanent work.

Ms FREEMAN - No, the bank will not give them a loan and they have to bring families with them.

Ms ELLIS - We have mental health nurses who have been turned away because they cannot get permanency so it is actually right across the board, and it is impacting on being able to attract people here.

CHAIR - I guess you have looked at other systems around the world. If you look at the system they have in Singapore now where they have addressed some of these issues with the retention of nurses and getting nurses back into the system and so on, one of the things that they looked at was absolute security right from the word go, in other words, bringing nurses in with a secure position. It has assisted them with their recruiting and assisted them with their retention and they say they now have a very good system running very well.

Ms ELLIS - It is very rare for a nurse to start employment here and go straight into a permanent job. Most of them come in as fixed-term contracts and serve their time, so to speak, and have rollover contracts and then they can finally get a permanent position.

Mrs SMITH - But that is the same in a lot of the public service. Teachers are the same, very few student teachers that start first year out get permanency for *x* number of years.

Ms ELLIS - In the last stats we received only 30 per cent of the nursing work force were on fixed-term contracts and the average in the public sector was more about 10 per cent to 15 per cent, so it was particularly bad for nursing.

Mr WING - It is good to hear that trained nurses from the mainland were interested in getting positions here. What is the difference in remuneration generally between Tasmania and other States?

Ms ELLIS - It is about 6 per cent on average, so we talk about a nexus.

Mr WING - Less here?

Ms ELLIS - We are less. That is the average of the other States so if you looked at New South Wales then we are significantly behind, it is around $300 a week behind New South Wales, which is quite significant.

Mr WING - It is.

Ms ELLIS - Queensland now have just been offered 4.54 and 4 per cent and that is a new agreement starting now. There are other States that are recognising the need to be competitive and, as Jane actually mentioned, it is a very competitive market out there and nurses can get jobs wherever they want to so health professionals are choosing where they want to go and the conditions and remuneration are significant.

Mr WING - The quality of life here would probably attract them to come here and have less income?

Ms FREEMAN - I think so, maybe.

Mrs SMITH - Not if they had to do six months -

Ms FORREST - It's like asking the doctors to do one in two; they do not want to do it, or only one.

Ms ELLIS - They do move on. I am conscious of the time so could we move to emergency first and reschedule your agenda if that is okay because Diana Morrison is here.

Mr WING - Otherwise we will have another emergency.

CHAIR - Concentrate on the areas you need to.

Ms ELLIS - I am sure we will cover it all, with your indulgence. If we could move to our paper and we will look at the Emergency Department.

Things again have changed considerably in Emergency and we have had some real improvements, particularly at the Royal with ramping. Ramping has decreased quite significantly with the opening of a short-stay unit there and that has really taken the pressure off. At the LGH we have had some improvements in bed blocking with the additional transitional care packages or community packages for aged care and the better movement of patients into the appropriate aged-care facilities. Overcrowding still

remains. As of this morning, the LGH has 20 bed trolleys - their set capacity is 20 - and they have 35 patients in there, so those other patients will be on mattresses, chairs, walls or wherever they can be put.

Ms MORRISON - It is really quite challenging as a health care professional to treat patients on a chair in a waiting room. It is very congested in our department and very unsafe because we just don't have the beds or the space to support the people who are coming in. What we are finding is that our numbers in the community are increasing so we are getting more and more presentations. If you look at our latest statistics - and I know we have this flu pandemic happening now and we have the flu clinic which has taken some of the pressure off - our numbers in the last six months with presentations have increased significantly and we just don't have the capacity - doctors, nurses, beds - to accommodate and manage it safely.

Ms FORREST - There's the patient privacy issue associated with that as well.

Ms MORRISON - Yes, it is very significant.

CHAIR - I recently had a patient come to me and complained that in that situation they were required to use urinals in front of people, in the corridor - he was embarrassed.

Ms MORRISON - That is an everyday reality in our department because you have someone down the corridor. We are under the pump, someone wants to go to the toilet, and we don't physically have the time to move them into even our pan room. It is quite confronting for us, as well as members of the public.

Ms ELLIS - With 35 patients on 20 bed trolleys, plus 15 waiting overnight - this was reported this morning, so this morning 15 were still there. Quite often they are there for 24 hours waiting for a bed admission, so that's not uncommon. Ditto at the Royal. Yesterday there were 36 patients, with 8 patients waiting for a bed since eight o'clock the night before and still waiting. It's not unusual at the Royal at all to have patients waiting on trolleys at least 24 hours for a bed.

CHAIR - This has been going on for a long time.

Ms MORRISON - It has.

CHAIR - So what is the system doing to try to alleviate that? Have they done anything at all or are they just putting up with what's happening?

Ms MORRISON - We are very good. It hits the fan in our department and it just all scurries and this is what happens time and time again, but we have no plan that has been implemented to stop it happening.

CHAIR - That's what concerns me and a lot of other people, that there is no forward plan.

Ms MORRISON - No. I have worked in our department when we have had three resuscitations going on in a two-bed resuscitation area. Everyone runs when we get these situations, but there is nothing that ever happens to prevent it happening.

Mr FOOTE - I have been liaising with John Kirwan through the DEM liaison consultative committee. One of the strategies that was identified early was that there were functional impediments in terms of getting patients out of hospital, and that was clearly around aged care. This is the transitional care programs that have been initiated and have been quite successful. In terms of the waiting times for placement for aged-care beds, that has been reduced quite dramatically down from 74 days to 30 days now, so that has been an effective strategy. What we are now seeing in the emergency department, albeit predictably, is that the activity level has moved from 100 patients to 120, to 140, to 150. So while we have at the back end a transitional program that is working, what we are seeing now is the activity. Because we have an ageing population, because we have such significantly bad health outcomes for Tasmanians, they are coming to the front end of the hospital, which is the emergency department, and that's where the big pressure is. What we are now seeing in the Emergency Department is acute presentations and with an ICU that is at full capacity and even with the transitional program, what we are seeing in the last six months is a new phenomenon, and that is based around acuity and activity.

Ms ELLIS - We are meeting on a fortnightly basis now with John Kirwan, the clinical director, and a management team. Some of our nurses are meeting with them to try to move things forward. I am trying to put everything on the table and come up with some solutions. There have been some improvements - and you are looking at some of the minutes - in moving patients through more quickly into aged care and that has made a big difference.

Ms FORREST - We have heard there were a lot of acute presentations to the DEM which rightly are in the right place, but from your experience, are there a lot of people there who perhaps would be better off with their GPs or somewhere else? However they cannot get in to see their GP, which I know is certainly a problem in the north-west and probably in other parts of the State.

Ms MORRISON - I was just about to talk about that.

Ms FORREST - Okay. So what is the solution there? What do we need? Is a GP superclinic the answer?

Ms MORRISON - We have many patients on pensions who cannot afford to go to a GP; they are not going to pay $60 to see a GP and then pay for pathology and X-rays so they will sit in our waiting room for six hours to get this free service. I believe that we need another clinical service in our area to take that backlog off our department.

Ms FORREST - What would be the percentage of cat 4, cat 5 patients in that position?

Ms MORRISON - Look, it would easily be 50 per cent. Don't hold me to that but it's a significant number.

Ms FORREST - Is that at all times of the day? Is it more during office hours?

Ms MORRISON - At weekends you find it; weekends are terrible. At long weekends, public holidays, evenings and nights.

Mr FOOTE - If I can support Di in that, one of the phenomena, particularly if I can talk about the LGH, comes from the model that is applied. The LGH operates a 9.00 a.m. to 5.00 p.m. model. Clearly, in terms of the ancillary service, it is business hours. The problem which has clearly been identified by John Kirwan is the fact that we need a 24/7 model and what we see from a client base is that, as the elective surgeries proceed during the week and we are operating that 9.00 a.m. to 5.00 p.m. model, the services are not there at the weekend but the patient numbers stay the same. Therefore we kick off again on Monday and what we have seen historically is that Mondays and Tuesdays are the worst days in the Emergency Department because we don't have the beds to clear out because we're simply operating a 9 a.m. to 5 p.m. model.

Ms ELLIS - That is actually right across all hospitals, not just the LGH.

CHAIR - It has always worried me. The police have always worked a 24/7 position because they have to, because that is when the work is; it is spread across the whole week, 24 hours a day. It is the same with the law.

Ms ELLIS - Nurses work 24 hours a day but, come 4 p.m., the cleaners, the caterers, the pharmacy and everyone else goes home and we have to do everything.

Ms MORRISON - Yes, and that is a huge handicap for us - radiology, pharmacy and pathology.

Ms FORREST - Are pathology 24 hours?

Ms MORRISON - No, they're on call.

Ms FREEMAN - They come in many times during the night.

Ms FORREST - At what cost?

Ms MORRISON - I don't know. It would be interesting to see the costs on that because not a night in our department goes by where pathology is not called in at least once.

Ms ELLIS - One of our recommendations is that we have 24-hours-a-day cover for pharmacy, pathology -

Ms MORRISON - And radiology.

Ms ELLIS - Obviously we are also putting in that we want after-hours support services for nurses. So an assistant in nursing is welcomed not to replace nurses but to come in and support nurses.

Back to emergency - we were talking about the overcrowding. We know at the LGH and the RHH that we have at least 16 to 20 emergency admissions needing a bed every day. So without putting any electives in, we need to have somewhere either discharging 16 to 20 beds a day or we need to have that capacity. We do not discharge that many patients a day so therefore we have the backlog. We discharge around 10 to 12 patients a day.

Diana will talk about mental health services - that is a real concern for us - and the impact on emergency services from mental health clients.

Ms MORRISON - Mental health is one of the major problems in our department and I believe that there is an increasing need for mental health services because we are getting more and more presentations of mental health problems and we do not have any mental health services in our department -

CHAIR - Working in the Emergency Department?

Ms MORRISON - Yes. There are always presentations and they seem to be increasing and we do not have anyone in our department who works with mental health. People must realise that emergency nurses and doctors are not trained in mental health and it is a highly specialised and highly skilled area. These patients, more often than not, are very combative, noisy, aggressive and take up a lot of time. When you look at issues with ice that is coming on the scene, we don't have either the facilities or the manpower to deal with them so we will call in a psych registrar to admit a patient to go down to 1E and they will say, 'No, we are not coming in; they have to stay overnight', so we have always been logged with these mental health patients that just wait and wait and wait in our department. They will tie up our security guards and often tie up the Police department and nursing staff because they are actually very intensive work.

Ms FORREST - On what basis does the registrar say they will not come in?

Ms MORRISON - We always have a long argument with this and this issue has been going on for a number of years.

Ms FORREST - Are they paid an on-call rate?

Ms MORRISON - Yes.

Ms ELLIS - We have just put a proposal in now to decrease the numbers of nurses on night duty at Northside, so that means that all mental health clients who are admitting would have to stay every night in the Emergency Department with no consultation with the actual hospital.

Ms MORRISON - And we really do not have the facilities or the time to manage these people. They are potentially dangerous to the rest of the patients and the staff.

Ms ELLIS - The Royal put in psychiatric liaison nurses. That was again an OH&S risk assessment because that was actually getting out of hand down there so we negotiated a psychiatric liaison nurse and that has worked very well. It has reduced the number of code blacks, which are emergency calls for violent, aggressive patients. It has actually been really supportive for the other emergency nurses to know and to gain that sort of expertise advice, so that has been really successful but it is only implemented at the Royal. We were proposing that it should be right across all levels of the department.

CHAIR - Do you know why it has not been implemented at the LGH?

Ms ELLIS - Costs. John has put business cases forward but it is purely about costs.

Ms MORRISON - It would make a significant difference if we had a psychiatric liaison nurse that worked in our department 24 hours a day. Someone comes in and we do not know how to manage them, so we would put it straight over to them. That is out of our area.

Mr FOOTE - I think the 24/7 in that position is absolutely critical. We have talked about the nine-to-five model and clearly there are mental health services nine to five. There is a crisis assessment team that is available up until 10 o'clock at night, but as we know mentally ill clients do not present at nine o'clock in the morning. They will come on a Friday or a Saturday or whenever and it is at night that is critical.

Ms ELLIS - We do have a mental health hotline but that is failing in many ways. That is available after 10 o'clock at night. That is a mental health nurse who is on call, usually in Hobart, but she is also working full time so she is on-call during the night and then has to front up for the shift the next day, so there is a bit of unreliability with that.

Ms MORRISON - Yes, and it has not been successful.

Ms FORREST - Could I ask about why the registrar might say he is not coming in? If that registrar has to front up again the next morning then may be a reason to say no.

Ms MORRISON - It is the only health service that does not present overnight, like medicine, surgical -

Ms FORREST - Is that because you are under-resourced?

Ms MORRISON - Yes, hugely under-resourced.

Ms FORREST - The psych unit itself is under-resourced with medical staff and that is why they stay at home. I know what it is like to get called out in the night.

Ms MORRISON - That is right, so we will hold mental health patients with no mental health management or plan, so they have not been assessed. It is really an area which we do not know about.

Ms ELLIS - I think we have probably touched on the need for radiography and pathology 24 hours a day. That was our next recommendation - and access to pharmacy as well. We also raised emergency department issues and some of the ways to actually move people who do not really need to be admitted to beds for a long period of time but just need a short stay; that works very well at the Royal. But there is also a brilliant team that has been set up at the Royal called the ACE team. It is a community health multidisciplinary team that can actually get community services. People can actually go home rather than being admitted and waiting for ACAT assessment et cetera, so that ACE team is working very well but it is only at the Royal. Where funding is available it is actually a good implementation of initiatives.

Bed coordination: when you say that there should be a single point of accountability for all hospital transfers, quite often surgeons try to sneak patients through as emergencies if they cannot get them on the elective list. Clearly there needs to be a much better system -

Ms MORRISON - Of communication basically.

Ms ELLIS - And transfers.

CHAIR - So far evidence has identified that there is quite a big difference gap between the Royal and the Launceston General Hospital and probably the North West as well.

Ms ELLIS - Yes, significant differences.

CHAIR - Why is it so? What is the real reason for it? Is it because we have all the senior bureaucrats in Hobart?

Ms MORRISON - And we are the only hospital in the north of the State, are we not? We cannot go on bypass or anything and it often intrigues as to why we are not supported.

Mr FOOTE - The clinical services plan identified that, from the department's perspective, there was a tertiary referral hospital and that was the Royal Hobart. Clearly what that demonstrates is that the focus, in terms of providing the service, is dedicated to one entity. There are a number of opinions in relation to that. I hold the view that if we do not have two tertiary referral hospitals in this State then we have critical mass in relation to our emergency departments and our intensive care unit. In other words, if we have one unit that is always full and constantly full we have nowhere to go. If in fact we have two large hospitals - though I also include the North West because I think the demographics of the north west are critical. We should be building a system that is able to provide a service where we can go on bypass so that our intensive care units, when they are full, can refer to other entities as well. We have a big problem in relation to paediatric intensive care units in this State.

Ms ELLIS - There is only one. The other issue, then, is transport - again, to have some single coordination. The devolution to area management is a great move forward, however there does need to be some consistencies in statewide coordination as well. One of the concerns we have is that there is going to be siloing of service delivery potentially in the three regions without that overall coordination, and potentially some inefficiencies without that as well. So that will need to be monitored as we move through.

Ms MORRISON - We are getting a new emergency department. We have outgrown our department. Our new department will make a significant difference if we can have the right staffing. Bear in mind that it is all skilled staff. As Susi was saying, one of our major problems is that we cannot pull nurses from anywhere because they need to be trained and educated in this specific area.

Mr WING - Are they available in sufficient numbers?

Ms MORRISON - Not emergency nurses. Nurses are, but they need to be trained in emergency department or intensive care.

Mr WING - So what will happen when the new facilities are available?

Ms MORRISON - Logistically we will be much better off but then we will not have the staff, which does concern me.

Ms ELLIS - When we moved from the old to the new emergency department at the Royal, that offered a more modern environment and less double shifts et cetera, so they have full staffing at the Royal and they have increased quite significantly.

Mr WING - There needs to be more funding for that, too.

Ms MORRISON - Yes.

Mr WING - Not just for the bricks and mortar.

Ms MORRISON - Yes. Night duty have just put in a submission for some more night staff and I know that when we work on nights you really do not have a break. You will start work at 9.30 p.m. and you will finish at seven o'clock in the morning. You will grab a cup of coffee and take it out to the department but that is about it. You will work your whole 10-hour shift without sitting down and having a break.

A lot of my colleagues are grumbling and looking at moving on. These are the older ones and your skilled staff are 45 and above in age. They are the ones who really need to be looked after because they have the knowledge that they can impart to the young ones coming up. You probably do not hear this but I know there is quite a lot of chatter with my colleagues about moving on.

CHAIR - Is the system failing us in as much as they are not promoting to nursing staff that they need these extra skills to go into these areas where there many vacancies, in the emergency areas and so on? What is the cause of that? It is not attractive enough?

Ms ELLIS - No, it is always attractive. Usually specialised areas are very attractive because you can control your workloads. In ICU it is one-to-one. In emergency you normally do get backup. They are not doing as many double shifts now as they were.

Ms MORRISON - We are now; it has just started again.

CHAIR - Is there an explanation for not having sufficient numbers who have this expertise to move into those areas?

Mr FOOTE - Very simply it is because the nurse unit managers do not have the positions to offer.

Ms ELLIS - Permanent positions.

Mr FOOTE - Yes, permanent positions. I might go back to the reports that we wanted to table. For the benefit of the committee these are not new reports, not current reports. These are old reports that go back to 2006 and 2007. That is the demonstrated activity and occupancy at that particular point in time. Those full-time equivalent positions have not been put in place so from an intensive care unit perspective you need 14 FTE in 2007; we don't have them now.

Ms ELLIS - It's just to meet national benchmarks of critical care, intensive care, national acceptance standards and staffing, another 14 to cope with the load.

Mr FOOTE - So if the nurse unit manager doesn't have the positions she can't offer anyone any work so it's reliant on that pool of employees.

Ms FORREST - The difficulty is that you can't pull a nurse off the medical ward to come and work in ICU or in the Department of Emergency Medicine, whereas if you're in the medical ward and you are short you could call someone from the surgical ward.

Ms MORRISON - It takes a couple of years to train someone up to that level.

Ms ELLIS - But if you have a funded, vacant, permanent position you would attract someone to the position because it is a permanent position. ICU has a waiting list of nurses wanting to work there, and we know there are positions that need to be there but the funding isn't there.

Ms MORRISON - I know Susi was saying that our occupancy is always full but this impacts on us because we get an intubated patient and we can't move them out of the department, so look at what it does to our staff. It takes up our resuscitation bay and one nurse who could be out on the floor.

Ms FREEMAN - We should have a bed empty and staffed ready to go at all times and this is causing delays in moving the patients around the hospital. It is also having an adverse effect on our patients because there is risk of their condition worsening because they don't get a timely admission to ICU because there is no bed. We might have someone there and then we're trying to get a bed on the ward and move that patient out. The minimum time for us to move someone to the ward if there is a bed is an hour because that bed space has to be cleaned to bring someone else back in. What we want is a staffed emergency bed in our unit set up at all times so that we can take these patients in a timely manner.

Ms MORRISON -I'm sorry but I have to go. Does anyone want to ask me anything before I leave?

CHAIR - There possibly will be other matters come up. Thank you very much for the information you have give us and feel free, if there are other issues that you have not broached with us, to provide that information to our committee.

Ms MORRISON - If we can keep patients out of the hospital, say a better GP service, I don't know whether we can provide some form of bulk billing. I know this would make a difference. We need more nurses but how can we keep the community out of our hospital as well?

Ms ELLIS - The other issue now is we also have the potential for nurse practitioners with MBS and PBS rights. That is a real option now coming through from the Federal Government. Patients need to be treated by the person with the appropriate skills and education level; they don't all have to be treated by doctors and nurses. It is most important that they have quick access.

Mr WING - But we need more GPs because some people are moving from one practice to another and find that they're taking no new patients.

Ms MORRISON - That's right. I sit on that triage desk and every day you get a lot of patients who come in and say, 'I can't get into a GP'. It is a very under-resourced area.

Ms ELLIS - We provided a paper for the committee in regard to elective surgery, which we provided to the department as well. That has a range of about 30 recommendations sitting in the back of it. They still stand, very few of them have been put in place. On pages 6, 7 and 8 of that paper there is a range of clearly tangible recommendations that could be in place but just have not been put in place. There are things such as the appointment of a statewide transport coordinator to make sure that nurses are not sitting on the phone at five o'clock or six o'clock in the afternoon ringing around trying to find out which beds are available on the north-west, which community service is available to get them home. It is just ridiculous that we don't have a centralised, coordinated, 24-hour service so that clinicians do not have to do that work. There is a range here. Clearly there are some real inefficiencies. Now we have theatre suites that nurses are cleaning between cases. We would be much happier if we had appropriate support staff so that you finish one operation, leave that room, and move straight to the next one which is all prepared, ready to go and the whole clinical team can move through. It seems that we are saving a penny- whatever the phrase is - but we are pinching really. We cannot afford the support -

Mr WING - Penny wise, pound foolish.

Ms ELLIS - Thank you. We cannot support the simple solutions because it may cost a bit but the impact would be massive, being able to go through the elective surgery list a lot more quickly, which is about the community and this is what we are all here for. Unfortunately the majority of those issues have not been taken up. I am happy to take any questions on them.

Mrs SMITH - Many of the issues cross over State to Federal, like your bed blockage, for instance, and you cannot operate. Do you have an opinion on the current debate about whether it ought to be under one regime rather than across all Australia?

Ms ELLIS - We would not accept the Federal Government taking over the primary care setting; it does not make sense to do that at all. If the Federal Government is going to take over they would have to take over the whole lot. We clearly have some concerns about aged care and management from a Federal perspective on aged care and the massive bureaucracy. There have been concerns that we double up on bureaucracy by having Federal taking over.

Mr WING - So you do not favour that?

Ms ELLIS - The Federal takeover? If they are going to take over anything it would have to be the whole lot.

Mr WING - How do you feel about that prospect?

Ms ELLIS - We are still waiting to see how this area health integration goes because I think that is a really positive move forward, having regional health which we have not had in Tasmania for a long time but the focus has to be on primary health. The focus has to be on children's and school health and bringing back school nurses. It is ridiculous that we do not have school nurses anymore. Every other State has them but we got rid of them as a cost saving yet that is where you are going to pick up some of your change in behaviour, your slow learning which is going to impact on employment, on health, obesity, eating habits; all of that has been picked up in schools. It is about going back to the primary, not elective surgery.

Ms FORREST - And preventative health.

Ms ELLIS - Health promotion, preventative and starting with the whole family with a continuum of care. We are so reactive now.

Just looking at the solutions out of our elective surgery paper I mention to the committee that really none of these solutions that came from the nurses have been implemented and that is a cause of great concern and frustration for us. A lot of these may have a slight cost to them but the greater good is far, far better than the small cost.

Mr FOOTE - What we can also detail for the committee is, given what we are seeing in the emergency department with the activity levels, okay the activity levels are rising and obviously a percentage of that activity is elective surgery. It is my understanding that 40 per cent to 45 per cent of all it's the LGH's cases were emergency surgery. There is a great emphasis placed on elective surgery and there is inevitable tension about elective surgery being delayed and that then delaying the emergency surgery compounding with the presentations in the emergency department. What we are seeing are real tensions in the theatre suites about the capacity to do timely emergency surgery.

Ms ELLIS - From a hospital perspective the only variable we have is elective surgery; everything else is demands and demand is increasing. Emergency services, intensive care services, aged care services are all increasing so the only thing that can give in this tight system, which is 110 per cent occupancy, is elective. That is why the health planners are saying we need another 67 day-surgery beds just to get our elective surgery through. The push and the national incentives and targets and funding targets based on meeting numbers of elective surgery have come at a cost and that is why we have been really pushed in emergency areas now for the last two years.

Mr FOOTE - If I can make one point to give a really practical example in terms of the surgical area and the interface with the intensive care unit. When you have emergency surgery done out of hours - and these people are seriously unwell requiring an intensive care bed - and there is no ICU bed they have to be held in the theatre and that is absolutely completely not ideal to have ventilated, seriously unwell patients in a recovery area, and that is becoming a more recent phenomenon.

Ms FREEMAN - It is dangerous for the patients of course and is a serious risk to their conditions worsening before they get into ICU which will have a major impact on their outcome and whether or not they survive the episode. Sometimes we're full with patients, none of whom can be transferred anywhere. We may have rung all the other hospitals to try to get somebody out of ICU, to send someone to Burnie, Hobart or the

mainland, and no-one will take them. So there they just sit, basically, until we can sort something out.

Ms FORREST - One of the things that has been suggested and was part of clinical services plan was having dedicated day surgery units or elective surgery units, where there would be no interruptions to those because there is no capacity for those because there is no capacity for an emergency case to go through it. I think that is what was proposed for the Mersey and it would have been a godsend but the community did not understand it was part of the process and the political pressures were too great at the time. But we are starting to see that change with the endoscopy clinic and all the cataracts being done over there.

Do you think this is a way forward, having a dedicated elective surgery area? We are not talking about the things that end up in ICU as a planned event, but do you think this is a way of trying to keep the elective surgery ticking over and having a dedicated area so that you can't say, 'Sorry, we've got an emergency caesar coming through', which always annoys people tremendously? Do we need to focus more on that?

Ms ELLIS - We do dedicated day surgery at the RHH and LGH where they have their own dedicated theatres, so they are isolated and not reliant or dependent on the major theatre suite. The problem is that you can only really do minor surgeries there because anything else would need an inpatient bed. So they are at full capacity. They are really pumping through, those two areas, and have made a big difference for category 2s and 3s. But then they opened up at the LGH a 23-hour stay unit, which means you can go in there and recover for 23 hours maximum, so it is not really a true, ongoing requirement for a bed.

Ms FORREST - But you'd be there overnight?

Ms ELLIS - Yes, but what we found then was that emergency were banking up because they were four beds that had been taken away from the capacity for emergency admissions, so all of a sudden, emergency were banking up because the more complex electives were taking that four-bed bay of 23-hour suites. So that pretty much failed because we had to cancel those electives and bring the emergencies in, because they were banking up for two days and not just one day.

Ms FORREST - Again, the Mersey was going to also have the 23-hour stay. If you could have implemented that at the RHH and the LGH and have it dedicated, cut off from the rest of it -

Ms ELLIS - In additional beds, yes, but not take some of the current beds.

Ms FORREST - That's what I'm saying, as additional beds.

Ms ELLIS - Yes. You don't even have to have it; it is basic elective surgery. Many of the other States just have an elective surgery hospital; a dedicated hospital set up, as the Mersey was intended to be.

Ms FORREST - That's right. Then the people from the north could go the Mersey for their surgery.

Ms ELLIS - Or the south.

Ms FORREST - Yes, but certainly to the north. There is no reason they could not come to the Mersey for it.

CHAIR - I have just a general question in this area. The issues that are referred to in your submission have been there now for quite a long time. I noticed your submission was written in about October last year, wasn't it?

Ms ELLIS - Yes.

CHAIR - Have there been any changes in the system since then that would alter any of the recommendations you have made in here?

Ms ELLIS - Yes. We went through this with our council last Friday to have a look at it because things have changed quite dramatically. As I said in the introduction, with integrated health service now, with the new CEOs coming in, with the devolution of accountability and funding, things have changed quite dramatically, but many of them are still here. I am looking at page 7 of that which is talking about aged care and that has been identified as one of our blockers. But we have aged-care beds in the north-west and the north vacant so we are not doing very well with moving our patients to those vacant aged-care places. In fact in the north-west we had quite a few recently.

But there are other incentives like bringing in nurse practitioners and hospitals having outreach services. Our aged-care nurses are really pushed to the brink. They have one nurse potentially for 80 to 100 residents after-hours and all the rest are carers, so that poor nurse is actually accountable for absolutely everything that happens there, including the water mains breaking and everything else. But if we had nurse practitioners to go along to a group of homes and support those nurses, we could keep those residents in their homes for their blood transfusions. Post-op we could take them straight back to their homes, which is where they need to be. They should not be in hospitals and emergency departments because that is where they are going to get complications. Nurse practitioners are a big answer in that.

Mr WING - The rates of pay for nurses is less in the homes, is it not, than in the acute care hospitals?

Ms ELLIS - That's right.

Mr WING - Significantly?

Ms ELLIS - Yes, significantly. They earn about $180 less a week and their responsibility is far greater.

Mr FOOTE - There is also a change in the agreement-making process. Clearly in the past we had a central agreement that covered the majority of aged-care facilities so there was a direct comparison, but now because we are negotiating agreements for every facility, the wages differ quite significantly.

CHAIR - Just on the wage situation, the current position that has been identified - and I mentioned it to the last witness - what is the likely consequence of that?

Ms ELLIS - It has actually been going on since 1991 and we took it to the commission in 2006. We've tried to negotiate with the Government to say that nurses in Tasmania are not being paid the same for a public holiday as nurses on the mainland. Mainland nurses came down here and complained and said, 'What's this? We're not even getting paid double time for a public holiday?'. They had been raising it for a long period of time but in the end we could not negotiate. We have been trying since I came in as secretary, which was 2001, so we have taken it to the commission. The Deputy President handed a decision down in favour of obviously how we perceived the award was reading and we are now going through the argy-bargy of trying to get an order up together so that we can take it back to the commission. But there will be an impact. The Government should have been paying this for a long period of time but it will mean that nurses will get what they are now being paid on the mainland, so it is not any more than nurses are getting anywhere else.

Ms FORREST - But it will run into the millions of dollars.

Ms ELLIS - It will. Nurses are still not treated very well here. A nurse's child died - how awful - and yet they were not allowed to get leave without pay for 12 months. We had to come in and negotiate that, and the trauma that people go through; nurses are really treated really poorly in the public sector. If they can get away with not paying nurses what they are entitled to then that is great as far as the bureaucrats are concerned. It is a real disincentive and nurses get quite upset when they give so much goodwill and are treated poorly.

Mr FOOTE - I think the frustration is absolutely manifest. In 2006 and 2007 it was clear that was what we needed but nothing has happened, nothing has changed. Individual nurses, particularly because I work at the LGH, are well supported. We have good, effective managers in that particular entity. However I think the nurses' frustration is from the way they are treated as a collective group and as a profession. I think one of the things that I was actually totally disenchanted by was that the Clinical Services Plan is a 200-page document and nurses make up the greatest proportion of all health-care deliverers, yet there was less than a page that related directly to nursing in a clinical services plan, so I think that tells you what Neroli was saying about the respect that clearly the nurses see from the agency. We know that they have been regarded as being the most respected profession 15 years in a row, but that respect is not actually being given to them in that professional sense.

CHAIR - When we look at the salary and the numbers and so on, does the federation believe that the mix is right in the numbers for the administration services of the system and those who are actually providing the services?

Ms ELLIS - No, we have the worst percentage of clinicians versus admin staff in the country, I think just behind New South Wales, so we are right up there as far as being heavily bureaucratic as far as the system goes. We need support staff - we need more clerks, we need cleaners, we need caterers - we need them to support us to deliver the patient care. We do not want to be doing those roles. It is more the admin, the policy makers, the centralised bureaucrats that concern us more.

CHAIR - As opposed to -

Mr WING - A lot of other people.

Ms ELLIS - And other people. Yes, I am sure you have heard evidence in regard to that. I just raised with David Roberts last week one of the concerns we have in that they say we are devolving everything down to the CEOs who will have to manage, but they don't have the budget to manage the demand - there is no doubt that they will be struggling - yet they have cut recurrent expenditure for them as well now with no policy around - 'Right, we're going to be cutting this, this and this service on top of that to make sure you can cope' - and then they actually set these red, green and yellow colours apparently, not a traffic light system, but they have to meet these KPIs and those KPIs are that they meet elective surgery benchmarking across the country, which means nil waiting after 30 days which is impossible for us to do. They have to do that or they will put on an amber warning or a red warning. This is the culture now. The second KPI is no ambulance ramping. For the RHH they have done a brilliant job decreasing ambulance ramping but it is absolutely impossible because of capacity to never have an ambulance on a ramp or to have one patient waiting in an ambulance. So there are some really unrealistic expectations by the bureaucrats.

CHAIR - From a union's point of view, what system do you believe is operating reasonably well? If you look at the other States or if you look outside Australia, is there a system somewhere that you would believe is probably the benchmark at the present time?

Ms ELLIS - There are different areas and different hospitals and different management styles et cetera. But certainly Flinders is working beautifully at the moment with a lean system. They have absolute full support. It is about culture, about making sure we review every system we do and make it as lean and as user friendly as possible, so it is all about patient care. How can we stop a nurse walking down that corridor 10 times to go and get an IV bag and wasting that time? They track the time and they put in better systems. It is called lean system thinking and it is working beautifully in many other States. We have raised this with the minister. We have to have the resources to bring it in properly, not at the side of our desk, which is always our concern. We have to bring in projects for the sides of our desks.

Mr FOOTE - I think there are also systems, and often this is talked about in nursing circles, described as magnet hospitals. It touches on the point about recruitment. There are some key things that health professionals want. They want good clinical standard. They want support in practice. They want a reasonable workload and remuneration. If you have those things you attract the staff. In the States, particularly in some of the sites that we have seen, it is using that whole-management prerogative to facilitate that, so that clearly it is about making sure that there are good clinical standards and effective support in that. So you do not want to work one-on-one every night you have to work. Whether it is a doctor or a nurse, you have a reasonable workload and they are the key things that we are not seeing. We are seeing, as Neroli identified, almost a punitive system of management if you do not meet the KPI.

Ms ELLIS - In regard to another example I noticed with Jane Holden, the recruitment system is delayed strategically as a cost saving. That whole system of position numbers was

brought in originally as a cost saving to control when we employed staff and when we could have a big delay to try to save some money. That has gone now. So that is one of the things that has gone.

I will just spend the last few minutes on work force planning because that is probably critical for us. Sue rightly picked up that we 1 000 undergraduate students at the moment and around 140 enrolled nurse students at the moment. That is more than enough for our future if we look after our graduates. But the key issue is, how do support them in practice for their clinical support. We do not have enough clinical nurse educators. Our position is that we should be having one clinical nurse educator per ward, per unit, wherever you are working. At the moment in the primary health setting, as you know there are country hospitals with palliative care right across. We have one clinical nurse for the south, one clinical nurse educator for the north and one clinical nurse educator for the north-west. Three for the whole State.

Ms FORREST - There was a lot more funding about three budgets ago.

Ms ELLIS - That was an election promise from Lennon that we get 43 positions. We still do not have them. But that does not meet the need of one clinical nurse educator per unit. If we do not have that then we cannot support our graduates and they do not get a good clinical practice. So it is just an impounding circle. Our positions there are pretty clear, that we should be making sure that every graduate who wants to stay in Tasmania should get positions.

This year we have 325 third-year students, and there are only 120 graduate positions. So straightaway they know they are going to look elsewhere and they have been told at university to go elsewhere because you cannot get a job here in Tasmania. That is appalling for our registered nurses when we look at our average being around 50 now in Tasmania. There is no re-entry program available in Tasmania. It has not been available now for 18 months and that is, again, bureaucratic bungling of not having a current re-entry program. That is for nurses wanting to come back. So nurses at the moment get incentives from the Federal Government to come back to nursing but in Tasmania they cannot because there is no re-entry program available.

Mrs SMITH - Why is that so? Were there not re-entry programs?

Ms ELLIS - There were but they lost accreditation for the program and have not redeveloped it and put it in place.

Mrs SMITH - Whose responsibility is that?

Ms ELLIS - The chief nurse's office in the department

The other issue is the career structure, which is so important to make sure nurses have a dynamic career structure. Our career structure is now around 25 years old and we have in our agreement an agreement to undertake a new career structure which would really start looking at making it relative to the other States. They have deferred that now because they told us initially it was because the CEOs could not afford to put a career structure in for nurses. That is not acceptable either.

At the moment we have nurses working in team leader roles with allied health or other health professionals and for the same team leader advertised in the paper a nurse gets $15 000 less now than allied health for the same job. There are the two different awards in there. There are some real disincentives there.

Mr WING - The specialist doctor at the LGH who was in charge of the kidney dialysis section and who went to Brisbane made some complimentary reports published in the *Examiner* about the hospital system in Brisbane. How does that compare with Flinders and with our system?

Ms ELLIS - I am happy to provide some examples of what we would consider best practice hospitals. Maybe that might help the committee.

CHAIR - We would appreciate it.

Ms FORREST - On that line, Neroli, you went to the UK with a study tour. The productive ward initiative there is similar to what you are talking about?

Ms ELLIS - Yes; it is one of the tools in a simplified system. It is the lean system principle that we are talking about. Victoria brought in a fabulous system and obviously funded that appropriately with all the tools on-line so nurses can access it. Nurse managers, site by site, ward by ward, are trying to bring in their own system with no project management support.

Ms FORREST - It was going to be a big rollout with big support.

Ms ELLIS - It was meant to be.

In regard to the career structure, one of our key issues is our nursing unit managers, who are brilliant. They are managing multimillion dollar budgets, 60 to 100 FTE staff, and yet they really do not get any training at all. So one of our key recommendations is that if you are going to have people who are excellent clinicians and who often get to nurse unit manager positions because they are excellent clinicians, they might not have potentially the management training skills and do not get the support, and our IT systems are letting us down. A nurse manager cannot even get a report on the cost of pharmacy used that month on her ward. She can't get the report on any of those costings. So how do you manage your budgets when you do not have the information?

Ms FORREST - And to get the number of caesareans for that month you have to go to the book and count them up.

Ms ELLIS - Yes.

It has been really beneficial bringing in the southern campus for nursing; it has been a great boon and is absolutely to capacity. In fact to get into that southern campus you have to have a tertiary entrance ranking of 88 minimum, which is very high for nursing and that shows the demand. So we have plenty of people wanting to nurse.

Mr WING - How does that affect the numbers in the northern campus?

Ms ELLIS - Still full. This year we have over 400 coming into our first year, 484 in second year and 325 in third year.

Mrs SMITH - So if that many want to be there and are pushing up the entrance standards are we going to get to the stage where the standards are so high that we start to find people do not want to be nurses because they may as well be a doctor? The best nurses are not always those with the highest qualifications.

Ms ELLIS - No, we understand that but it is purely a system problem that they are looking at the points only to get into nursing at the southern campus. I gave that as an example of the demand for it.

Mrs SMITH - So they need more points than in the northern campus?

Ms ELLIS - Yes; for the northern campus you do not need those points.

Mrs SMITH - That is a nonsense.

Ms ELLIS - It is demand driven. It is actually more like 60 points for the north.

We also have our enrolled nurses and it is really important to remember that we work as a team. So we do have registered nurses, high-level nurse practitioners, but we also have enrolled nurses. We are absolutely not opposed to assistance in nursing, but not replacing nursing positions - and that is the bottom line. We need to have qualified nurses where you need them. The acute setting is just getting more and more acute in the hospitals.

Mr WING - How many student nurses are there in the northern campus and how many in the southern?

Ms ELLIS - Two hundred in the south - that is capacity; they cannot take any more - and 800 in the north. Of course they have Sydney campuses where they have additional nurses. David Roberts view is that we should be an exporter of graduate nurses.

Mr WING - We are.

Ms ELLIS - Yes. They come down and poach them. They love Tasmanians -

Mr WING - Because we are not employing them.

Ms ELLIS - We need them. Then we get shortages in specialty areas because we can't have that flow of younger nurses coming through.

Mr WING - We are but we shouldn't be.

Ms ELLIS - I know.

CHAIR - Are there any concluding comments you would like to make to the committee?

Mr FOOTE - There are a couple of documents that we would like to table from our Federal office. One of them is a really important document for ensuring quality and safety and positive patient outcomes. It is highly detailed but it is an evidence-based document and it demonstrates the comparison between cost and the money spent on health care and the outcomes for clients and patients. We know we have an ageing population and that includes our work force. We also know that we have a demographic in Tasmania where we have the worst health outcomes. This is an important paper because it demonstrates the need to spend appropriate amounts of money on health care.

The other is another document from the Federal office which talks about unlicensed workers and the risks associated there.

CHAIR - We thank you very much for the evidence and the information you have passed on to us. Our position is one of trying to make changes in the system that would benefit the people and the staff.

THE WITNESSES WITHDREW.

Dr MARIELLE RUIGROK, STAFF SPECIALIST, EMERGENCY MEDICINE, NORTH WEST REGIONAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Dean) - Welcome, Dr Ruigrok. For the purposes of *Hansard*, could you please tell us a bit about your background?

Dr RUIGROK - I am 47 years old and I've been in medicine for almost 30 years. I started medicine in 1980. My current position is as a staff specialist in emergency medicine across both the North West Regional Hospital and the Mersey Community Hospital. I am half time at each campus. It works on a four-day week, four 10-hour days. So I am two days at Burnie and two days at Mersey. At Mersey my role is Director of Emergency Department, but also clinical governance and I have a role hospital-wide in that area. I have come from working as the Director of Emergency Medicine at the Calvary Hospital in the ACT, which is a public hospital attached to a public and private hospital system. There are only two hospitals in the ACT. This was the smaller hospital. The emergency department there saw 46 000 presentations per year, which is about the combined presentation rate of both Burnie and Mersey. I come from a much bigger system. I also come from a political system; Canberra is the home of politics and bureaucrats. One of the reasons for coming to Tasmania is that you're not so close to the politicians.

Ms FORREST - Except now.

Laughter.

Dr RUIGROK - Well, I think partly the problem with politicians is they get advice that may or may not be from people who understand what is required. I think politics is on a three-year term whereas really with health we need to look at more 10- to 20-year terms.

CHAIR - Except in our case, we are there for six years.

Dr RUIGROK - That's even better; it's closer to 10 than three. It is a substantial, important thing. It is important to understand the politics because unless you understand the politics and effect a political solution, you're not going to effect a health solution. An understanding of those realities is required.

In 2007-08, I took a year of leave. I felt I was becoming too narrow and too entrenched in my own little system and I wasn't able to see the big picture. During that year I worked in several States in different hospital systems to look at how they do things in other places. Often the best way to find out how a system works is to work in it, not as a consultant or 'I'm coming here to look at your system', but just as a worker. I worked in Queensland; I worked at Rockhampton and Bundaberg. I also worked at Nambour and Caloundra. I will talk a little bit more about the Nambour/Caloundra system later on because I think that there are some real lessons to be learnt from that system. From an emergency point of view they seem to have some systems in place that are really excellent. I also worked at Bathurst, which I felt could have used some improvement and certainly is a lot worse off than we are here. I worked at the Mersey for eight weeks.

I also worked at Lismore Hospital, which is another system we can have a look at. So I worked in New South Wales, Queensland and Tasmania. I didn't work at all in Victoria, South Australia or Western Australia.

CHAIR - Marielle, thank you very much for that overview of where you've been because that is very important with the evidence you're going to give us today. You have indicated that there are some general issues you want to raise and you have seen our terms of reference on this. You might be able to go through those in a moment as they appear on our documentation.

Dr RUIGROK - I would prefer if you ask me the questions and then I can answer specifically.

CHAIR - Do you have any general comment you would like to make at this stage on where you stand and the way you see things in this State?

Dr RUIGROK - I think your biggest problem in this State is the fact that you have the population of the ACT in 10 times the area and I think overcoming that is going to be quite difficult because you can't have a catheter lab in every little hospital, or an MRI in every place. Accessing services is probably the biggest issue you have here, not just from a money point of view but from a travel point of view. I think, from my point of view, the thing that we really need to be working on is looking at how to get the patient to the centres of excellence in the different areas around the State - and not just the patient but the patient and their family and how we communicate. I also think it is very important what data we're using to base our services on. On my brief look at the data here, I think the data is completely and totally inadequate. The indicators that we're using are not really reflecting what our business is. I don't want this to be misinterpreted but in some ways I think we need to treat health more like a business, in the sense that we need to know our business a lot better, and the keystone to that is data. When the person before me was speaking about Adelaide and Flinders and lean thinking, one of the keys of that is that they looked critically at what they were doing, collected the data and looked at what they needed to change. I think the data we're collecting is incomplete and what we're pulling out isn't reflecting what we need to know.

Ms FORREST - So what do you suggest in that regard? What data should we collect and how should we collect it?

Dr RUIGROK - I will give you an example. From an emergency point of view we collect waiting times per triage category and we are beaten over the head with constant regularity in the media, privately, publicly, yet it is not actually useful to do that. Does it make any difference really if a person who is given a category 3 - which is urgent - is seen within 30 minutes or 35 minutes? No, it makes no difference at all. What really matters is that those people who are critically ill and need to be seen now are seen now-ish and those people who aren't critically ill are seen later-ish. That is something that has been looked at by the college and I think we'll see a change in how we triage, manage and steam these patients. It is also a very gross tool because it lumps a whole bunch of people together. For example, category 5 patients are often classed as GP patients but category 5 patients are not the same as GP patients. GP patients certainly are amongst those category 5 patients but they are not the same group. So we need to look at the different ways of doing that.

Access block in terms of the data: we currently measure access block as number of patients waiting more than eight hours in an emergency department. Whether that one patient waits nine hours before getting a bed or 29 hours before getting a bed, that is still classed as one patient. What we should be looking at is number of hours of in-patient care provided by the Emergency Department, which will give you a better idea of how many in-patient beds you need by the number of hours of in-patient care that is provided by the Emergency Department.

Ms FORREST - You can attach a cost to that, can't you?

Dr RUIGROK - Yes, then you can attach the cost and then you can look at your staffing ratios and then you can look at how you could better staff it. We call it the Department of Emergency Medicine. It is actually the department of available medicine. So we do emergencies as a part of that work but it is the only place in the whole system where there is 24/7 care.

Mrs SMITH - At no cost.

Dr RUIGROK - We are considered to be completely expandable. So while the ward can say, 'no beds, cannot take that patient', if a bus load pulls up with patients in the Emergency Department we are expected to deal with that within our triage waiting times. There is very little flex-and-contract ability there. We need to look at what it is you want emergency departments to do. Do you want us to be the entire intake system and do in-patient care? If so, then figure out how many hours we are doing it and staff it properly. Or is there a better way of doing it? That is all I am saying. I think we need to change our measure for access block. We are so undercounting it. In ICU we count hours of ventilator use so that we have an understanding of how many ventilators we need. In the Emergency Department we just count patients and they all get the same waiting, which is ridiculous.

I will talk about Queensland. One of your biggest problems here, of course, is geographical distance to appropriate services and how we manage that. Currently the system working at North West Regional is that that is centre for the west coast and also for Mersey. So if we have a patient but not the in-patient services that we can provide at Mersey, then we have to send him to Burnie. I may have a patient, for example, with a broken arm who needs to go and have an operation. So I need to ring up Burnie; they accept the patient but instead of going direct to a ward or direct to a day surgery unit or direct to somewhere where they can have that operation done, they go into emergency at Burnie. They have already their emergency care at Mersey, but they go to emergency care at Burnie and then it may take *x* time to be seen by the registrar who then has to figure out whether there is an operating time available and who then might send the patient home, only to come back some other time in the future. So we are double-handling a lot of these people. It is inefficient.

What I would like to see happen for a patient with a broken arm at Queenstown is to look at the X-ray, telephone the orthopaedic registrar, yes it needs an operation, book a time, come up at this time, have your operation and go, bypassing the second Emergency Department.

As I said before, I do not have good data at the moment. I still have to clean up the data from Mersey for the last financial year. It is a bit like garbage in, garbage out. Our computer system recording what we do is inadequate - probably the nicest thing I could say about it. The system itself is okay and when you look at these systems they look fantastic because you see the Rolls-Royce version. But then the State Government buys the budget version which does not do the job that you sought to do.

In Caloundra, Queensland, they have a hub-and-spoke model where Nambour is the hub and there are about six spokes. Each of those spokes have a director of emergency and the hub has a director of emergency, and there is an area director of emergency. The area director of emergency will do a shift in each one of those spokes plus the hub about once a fortnight, and he does all the administrative stuff and liaison with other committees.

I worked a week there. I did three days in Nambour and four days in Caloundra. Caloundra was a hospital much like the Mersey. It did not have surgery, intensive care or HDU; it has medicine and rehab. It had less than Mersey but you had specialist staff in it and they were able to sort the patients out, so if they needed admission to Nambour you rang up the appropriate person. They said they would take them and they went straight to that appropriate ward. They did not come through another emergency department. The system was set up to transport people within a timely fashion to the right place in the right time frame, so you were not doubling handling.

Ms FORREST - Just on that point, we had evidence from Jane Holden earlier that we now have the 'hot' position.

Mr RUIGROK - The which position?

Ms FORREST - You have not heard about the hot position?

Mr RUIGROK - Not yet.

Ms FORREST - It has only been rolled out this week. I am not sure which one it is exactly but she said not to get too excited. It is being launched this week or next week. Effectively it means that the GP who has a patient - and the same could apply for a doctor at the Mersey DEM where the service is not available - and has made a medical assessment of this patient's need, then rings the physician direct. He does not ring the junior resident at the DEM or the junior resident for surgery and then to the registrar and on we go up the tree. They go directly to the position. So there is a direct hotline to the position so you cut out all the other steps. Is that something that should be considered when you have a situation like that, or even someone could present at a doctor's surgery who needs a surgical procedure and could then talk to the surgeon rather than -

Mr RUIGROK - Yes, that is very important. Having people at the top of the tree making the decisions and telling the juniors what to do is extremely important, but it is not the whole thing. The current situation is that the Emergency Department have a single point entry system into the hospital. There are two entries: there is the elective surgery entrance way and then there is the emergency entrance way. I can tell you now what will happen with that hot position thing. You will be ringing the physician up and they will say that it sounds like a pulmonary embolism, so send them in and I will get my registrar to say to

send them into emergency, so they will still send them into emergency. Yes, they have accepted their care but the Emergency Department will still be responsible for doing the work-up, will still get the registrar down to see them and there will still be a need for a bed. Unless you free up in-patient beds for these people to go direct to an in-patient bed, and provide the junior and registrar staff to see these people in the ward, and provide access to the diagnostic modalities for which to investigate that patient, then that is not going to work. It may actually increase the process of, yes, accepting that patient for admission but unless you fix all those other things underneath then it is still going to still be a burden on the Emergency Department.

Ms FORREST - One of the issues was to avoid admission. It was not necessarily people who needed admitting. It was people for whom perhaps the GP was more concerned about management of their asthma, diabetes or whatever it is, so the call was made earlier rather than later to get some advice from a physician about whether we should change medication or do a different range of blood tests.

Ms RUIGROK - I think that will work for a small percentage of patients. If a physician who is on foot today gets rung about a patient he has never seen before and talks to a GP whom he does not know very well, he may or may not be able to trust what the GP is telling him. I have been in that position because as the admitting officer in emergency we normally get those calls. Sometimes I am able to get them to the right place and sometimes, because the information is incomplete - though not through fault of anybody - I cannot make that decision to change a medication or to do that over the phone without seeing the patient. Otherwise it could be dangerous. So I think it can work for a small number of patients.

Ms FORREST - It may take time too to develop that system of trust and mutual respect.

Dr RUIGROK - It does, and in the medical field particularly at the Mersey the work force is completely unstable - it is locums from week to week, which is something that is being addressed and it will take time. I think that over the next three to five years we will see a change in that. It is difficult to sometimes make these decisions over the phone.

Often when the GPs are ringing, it's not so much that they need advice over the phone but that they cannot handle a patient anymore in that environment as an outpatient.

In paediatrics I think it might work well. Most of the patients that the GPs send in for paediatric review are discharged home after review but they may need investigation, tests and review in order to make that decision. It may or may not make too much of a difference. Sometimes what you hear over the phone and what you see when you get into the department is very different.

CHAIR - Just to go back to the hub-and-spokes model as you say, is it Caloundra that is operating at the moment?

Dr RUIGROK - Nambour is the hub.

CHAIR - Does that create more administrative positions and so on?

Dr RUIGROK - No.

CHAIR - Evidence has been given to this committee and we know that it has been said that there are too many in administrative positions within DHHS in this State and that we need to start looking at moving some of those and bringing more people who work at the coalface.

Dr RUIGROK - It worked very well. I had a patient at Caloundra with appendicitis who couldn't be handled there. I rang the surgical registrar who said yes, it is appendicitis, send it over and he gave a particular code, which usually was the date, the number of patients he had accepted that day and the ward they are to go to. The surgical registrar was responsible for organising the beds so bed management was phoned to organise a bed. When you gave that code to the ambulance the ambulance knew exactly which ward they needed to go to so they went directly to that ward. Therefore, you did not need an extra administrative person, you just needed to use the system a little differently. Does that make sense? Rather than say to send it to emergency and we will sort it out when you get here.

CHAIR - From your experience in the areas that you have worked around Australia, do you think we have the right mix here with administrative staff ratios compared with those working in the coalface - the doctors, the nurses and so?

Dr RUIGROK - I really cannot comment; I have not been around here long enough to know about the level of administrative infrastructure. I come from Canberra which has the highest ratio of administrative staff to clinical people in the country so this is less than that. What is the right mix? I don't know. Certainly there are ways we could deal with our work force a little bit better. For example, I spend a lot of my time doing administrative tasks picking up the phone trying to get hold of someone, writing up the notes, ordering things, walking around getting the X-ray reports. There is a lot of administrative rubbish that I do that takes up my time. For example, yesterday I was working at Burnie and saw a patient who clearly needed to come in. It took me about two minutes to make that diagnosis and I had a medical student with me which was fantastic because he then spent the hour writing it up and I could go and see other patients. It then took another couple of hours to get engagement of the surgical registrar and the various other people to get them to the ward and to get a bed.

I am paid a lot of money. I am paid to make decisions about who comes in and who goes home and what treatment they should have. To use me the most effectively that is really all I should be doing. I shouldn't be wasting my time writing out X-ray forms, writing out path forms, lots of rubbish.

CHAIR - That brings me to my next question. Evidence has been given to this committee that there is too much red tape there and there are too many things occurring in the administrative side. From what you have just said, that is just not necessary and a lot of it is duplicated, even triplicated throughout the system.

Ms FORREST - No, we're not saying that.

CHAIR - No. I am just saying that that is some of the evidence that has been put to us.

Dr RUIGROK - It goes together, the whole range of different things. Firstly, we do not have an electronic medical record that is real time. We have two systems; we have an electronic system that is completely useless and we have a paper system which we cannot access. I have to enter data on the computer system and I have to write notes. We have patient Joe Bloggs, who we know comes into the emergency department and he has complex medical diseases, so he comes into emergency at least once a year, if not a few times more a year. So every time he comes in I have to rewrite his past history, rewrite his medications, rewrite his allergies, rewrite his social history and all of this stuff. If we had an electronic reader where all of that is already documented, all I really need to do is edit what is already there, if things have changed, and just write in why he has come in this time. That would save a hell of a lot of documentation. If I had a computing system where all the observations were put on the computer, anybody could access it at any time. It is just hopeless.

Mr WING - I am surprised that is not the case.

Dr RUIGROK - We spend more money on IT for the Australian Open and McDonald's than we spend on IT in health.

Ms FORREST - It is abysmal and has been forever.

Dr RUIGROK - It is abysmal.

CHAIR - I thought they were getting all of that right, that there was evidence given to the committee that they were getting all of the systems connected up so that you could just put the name in and get all the information and detail that was there.

Dr RUIGROK - I think there is a move towards that. I think it is a very slow process; IT is very difficult in the sense that every little clinical unit has their own idea about what they would want. Trying to get something that suits most people and that serves the purpose of allowing people to be treated in an appropriate way is, in fact, quite difficult. I would love to see a situation where the patient, the GP and other allied health services could access the record, so that you have a full and complete medical record at all times. I would like that Australia-wide. I think that is a long way off.

One thing we can start with in Tasmania is having a unit number, which I think has already been happening, that is unique for each person in Tasmania so that no matter whether you go to a Hobart hospital or one in Launceston or whatever, that same number comes up and you can access it.

Ms FORREST - They are still working on that but it will only be in the public system, initially at least.

Dr RUIGROK - Initially. The lack of information is a problem if you have someone who comes in who has collapsed and is unconscious and at the Mersey it is a paper record and the record might be in Burnie, there are no family members, there is nothing and there is no information.

At the moment we do a lot of 'work-arounds'. I will ask all my staff to write discharge letters on the computer so that if they come back in I can access what their history is on the computer, but it is time consuming. There needs to be a better way of doing it.

In St George Hospital in Sydney they have what is called COWs, computer on wheels, where you have computers in the Emergency Department where the nurses document all their stuff straight into the medical record, where you can put your notes in at the bedside and where you can develop a real-time medical record. There are systems around where you can dictate notes and that is sent to India where they type that into the medical record. There are many systems around. There is a lot of information out there.

Ms FORREST - There are PDAs out there now that you can use at the bedside to type in the treatment -

Dr RUIGROK - Yes, exactly, and little tablets or whatever.

Ms FORREST - Yes, small tablets or PDAs.

Dr RUIGROK - I think the key thing is having these systems that are available. I think one of the most appalling things I have come across in Tasmania is the fact that the mental health record is not part of the medical record, which I found astoundingly backward. It would not happen in any other State. When I spoke to Mental Health about this and said, 'Why do you keep this separate, this is just silly?, they said, 'Oh, because of discrimination'. I said, 'Yes, I understand it is a small community, but surely we have moved beyond discriminating, at least in the health professional area, against people with a mental health illness'. They are on drugs, they are on medications, they may have particular reactions to things, they may present in a certain way. For example, they may be suicidal but they always present very well and say that they are not suicidal, and that alert would not be available to me if they presented because it is not part of the record even if I asked for it. Having these records as a complete medical record and available I think is extremely important for patient care. I think we really need to look at getting over that and I think it says a lot about the profession that they feel that they cannot have a complete medical record with mental health because they are worried about discrimination. I think we need to change that and there is some evidence and the people I talked to said that they agree with me that that needs to all become part of the medical record.

Your biggest problem here I think is transport, waiting for transport to places of excellence. I will give you an example of where I think we should be going in terms of heart disease. The north-west region has the dubious distinction of having the highest rates of cardiac disease, obesity and smoking in the country. I have been here for three months. I would see a heart attack that needs cardiac catheterisation about once a fortnight where I came from, once a week to once a fortnight, and that is one patient so that is 50 patients out of 46 000 that would need a catheter. The other week at the Mersey we saw four in a week and it sees half the presentations. That is just phenomenal. What we should be doing with these patients is using our ambulance service as the hospital, the ambulance people delivering the care and taking them straight to a cath lab, instead of bringing them to, like yesterday, the Burnie hospital where they get thrombolysis and then they need to go Launceston. There is a delay in transport

because we do not have an ambulance that goes there, it has to be a plane and the plane is out on another call. It has to come back in - we go blah, blah, blah for four hours.

Ms FORREST - It should go that way to the airport or go that way to the hospital.

Dr RUIGROK - Yes. This guy was brought in by ambulance. We could have given him the treatment, put him straight back in the ambulance and with a fast trip to Launceston he would have got there much earlier, with less use of resources, less time and less cost. Better still, give the thrombolysis in the ambulance at Ridgley, which is were he came from, do not come to the Burnie hospital and go straight to Launceston. I am speaking with the ambulance service about that and they are very keen. It will take me a couple of years to get that in place. But with Queenstown, thrombolyse in Queenstown and fly to Hobart.

CHAIR - Does that happen as a result of the system that DHHS have got or simply because of the locality?

Dr RUIGROK - I think it is because it is traditionally treated in hospital. We have not been thinking a little bit outside the square. In Queensland they are doing a trial of this at the moment and it is working extremely well because of the distances. Queensland has the same problem with distance as Tasmania, it is a big State, and so they have evolved different ways of doing things. I think we are getting broadband rolled out in Tasmania which will probably be the best in the country and I think we really need to use that. We need to have access to videoconferencing, not so you have to set it up and book a time but we should be able to do that from almost any computer and have it at the bedside and it not to be difficult. It is almost easy to just get my mobile phone if I only had reception at the Mersey and if I just took some video and spoke on the phone. It would be almost as good and I think you need to have the right people in the right place. We could really use nurse practitioners in this State.

Ms FORREST - We are working on it.

Dr RUIGROK - The Mersey is a classic. I would love to have five nurse practitioners there with staff specialists and knock out a lot of the junior staff. They do need training -

Ms FORREST - Junior medical staff?

Dr RUIGROK - Junior medical staff because the junior medical staff are not as efficient as perhaps a nurse practitioner well trained and a staff specialist. We do need to train people. We have a lot of people in medical schools at the moment and we need to budget for training these people otherwise they are going to leave the State. We need to give them a good experience here. What Neroli said about nurses and education and training, apply that directly to doctors. It is exactly the same. I think also we need to support our country doctors a lot more. We put them out in the wilderness and we don't pull them in for training regularly, and we don't send them out. I think it would be advantageous to both the city and the country doctors if we swapped for two weeks a year so that we understand each other's problems. That is something for the colleges to look at, and that is a very difficult one, to provide accommodation and support for people to do that.

We have had a shocking tally for road deaths this year. I read in the paper - and I know this is not the most fantastic source of correct information - half a billion dollars a year. Is that correct? Could we invest that in infrastructure, say transport, trains, and get these cars off the road? It would help so much in getting people to their destination in good health if we had a decent transport system. It's not only the patient who needs transport to and from different centres of excellence, it's their families. Many people who require ongoing care in Hobart, for example the hyperbaric unit or whatever for gangrenous toes, sometimes need to be there for a six-week course in hyperbaric and they have no accommodation so they end up being in hospital for six weeks and using up a bed for something that can be dealt with as an outpatient. We need a think a little bit outside the square. Buy a block of units; make sure we have accommodation for these people and their families.

Let us get more streamlined in how we do things. In surgery we are doing a lot more day cases. For example, if you see a person who has gallstones and needs to have them out. If they come into emergency we diagnose them, we send them out for an outpatient appointment in surgical clinics. That happens in two to three weeks. In the meantime they may or may not get further attacks of gallstones so they come back into emergency and have the process done all over again, plus or minus the risk of getting complications. They then see the surgeon. The surgeon says, 'Yes, you need your gall bladder out' and then they get put on a waiting list. They may be on that waiting list for 6 to 12 months and then god knows how many times they re-present to an emergency department because they have ongoing pain. You have all these extra presentations and lots of days off work because these people don't go to work. You have their partners' days off work because someone has to look after the children because they are off work. You have the risk of complications which may or may not necessitate an ICU admission in the meantime and further morbidity and mortality. Why the hell don't we just admit them and do them the next day? It is a day-surgery case, why don't we just get a little bit more flexible and do things at the time rather than putting them on the waiting list? I saw a guy on Friday night with tummy pain, an otherwise healthy guy, and he was diagnosed with metastatic cancer that night on his ultrasound. Do you think I could get a CT scan that night to see if I could find a primary? Not a chance in hell. I sent him home - fortunately he was well enough to go home otherwise I would have had to admit him to hospital - and got him back on Monday for a CT scan. I saw him yesterday and said, 'Yes, you've got a stomach cancer primary. We'll need to do a biopsy. How about you come back on Thursday and we'll do a gastroscope? Then we'll do a biopsy and then we'll get you back to outpatients and decide what cancer it is you have. Then we'll think about putting you to treatment'. All these things that the family has to go through. Why not sort it out? We need to move from a 24/7 emergency department and a Monday to Friday 8 a.m. to 5 p.m. system in the rest of the health system to a much broader 8 a.m. to 8 p.m. Monday to Sunday system.

CHAIR - Why does that occur? Is it because of what is happening within the area that you're working or is it an expectation of the DHHS or because you don't have the right staff on?

Dr RUIGROK - No, this is nationwide. It is purely cost. Different budgets have different things. You have Commonwealth budget for some things, State budget for others and things such as work force and things like that are not even in the Health budget. When you look at the total cost of things, it might be in five or six different budgets but 'as long as it's not in my budget I don't have to worry'. Do you understand what I'm saying?

CHAIR - Yes.

Dr RUIGROK - There are staffing and cost implications to running things on a 24/7 basis or an extended-hours basis. We are a small population in a cash-poor State. We do not have the population to support all the things at one time. But I think we can do things more efficiently if we have a better way of slotting people into things. That hot position or hot surgeon would have been a fantastic way to go if I have a person with metastatic cancer and they need a scope. In fact, that is exactly what I did. I rang a consultant physician. He said, 'My waiting list is too long, could you speak to the surgical registrar'. So I was bumped back down.

Ms FORREST - The hot surgeon would not be able to turf like that, I reckon.

Dr RUIGROK - Probably not.

Ms FORREST - That is how it should work if is going to work.

Dr RUIGROK - Yes. Health is very difficult because it is an emotional subject. It is not just a business; people's health is important. It affects a lot of things. We need to get the people and funding right. I came to Tasmania for lifestyle. I came to Tasmania because I was promised a four-day week, which I am having so that I can do other things. There are enough emergency physicians in Burnie hospital, though not enough for the north-west, so that we can all share a load that is equitable, reasonable and so we all have a lifestyle. We have one paediatric surgeon in Hobart. It is unsustainable. What happens when he retires?

I think one of your drawcards to Tassie, and it is something we need to work on, is to promote that lifestyle theme because you have something quite unique here and we do not exploit that enough. Lifestyle is not just about the green fields and rain, which are very important to me; it is also about making sure your workload is not overwhelming and that you are not asked to do something unreasonable. So when you are looking at recruiting a specialist population, do not recruit one specialist because that is all you have funding for. Look at what your on-call is going to be like, look at what your workload is going to be and then think of what is reasonable to expect of these people. Do we really need three?

Launceston has a fantastic cardiac unit. I have had no problems with them. Every time I ring them they say, 'Yes, send it down.' They have been brilliant, but there are three of them - they need five. Why not recruit to that so that we have something sustainable. In that way Launceston can supply all the cardiac needs across the north and north-west. So we do not need a cardiologist in Mersey, Burnie and Queenstown but we have a centre of excellence in Launceston. We could take Mersey and say that Mersey should be the centre of excellence for rehab and outpatient care and day surgery. It needs a good emergency department to deal with the immediate things because the people need a service. They need available medicine. Even if you do, by some miracle, get enough GPs in that area, you are still going to need an emergency department there because GP patients are not the same as emergency patients. Why not put that there? Burnie has a more general hospital role, but we need to find niches for each of these areas so that

people find there is enough casemix to support a reasonable service there. So you can recruit three or four rehab doctors to an area.

Mrs SMITH - You are espousing what is known here as the Richardson report. To a degree it was put in the cupboard because in the whole mix of attempting to do it we got the public eruption and then you get the political process: 'No, we will not put that into the mix; we will buy it and put it into a different system'. Everything you are saying is correct but the political rationale and the population spread create the difficulties. Our budget is about half of the Tasmania State Budget for hospitals. We are spending it poorly or we have to put more money in. Which is it?

Dr RUIGROK - I think it is probably a combination of both. It is never just one or the other. There are some long-term gains that need to have money put in for which we will not see a lot of benefit for some years. There are some systems that we could certainly improve. In regard to politics, we need to engage the public better. Health by media is a complete disaster.

Ms FORREST - You can tell the *Advocate* that.

Dr RUIGROK - They are looking for a story. I was quite distressed about the 12-year-old girl who died, and that was played out on the front page of the *Advocate.*

Mrs SMITH - That is an interesting scenario and yet the *Examiner* has done very well at putting forward the issues of the Launceston General Hospital. They have achieved significant gains in finance and staff et cetera that they need. If you don't utilise your media to engage your community and your political arm -

Dr RUIGROK - It depends on how it is done. The way the *Advocate* has done it is about setting us against them, the poor battler against the horrible hospital system.

Mrs SMITH - Don't you think that the scenario has set the Launceston General Hospital against the Royal Hobart Hospital - they have it and we can't have it?

Dr RUIGROK - Yes, I think there is a lot of that - he big hospital and the poor cousin. You are not alone in this; it happens in every State. I was part of the small hospital-big hospital scenario in the ACT because I was in a small hospital. The big hospital had all the resources and so on. We can all play the poor cousin, but we need to move a little bit beyond that. The public is not stupid and gone are the days where we tell the public what is going to happen. We need to engage the public much more and we need to educate them.

The public still thinks that you come to hospital for a two-week rest. No, you don't come to hospital for a two-week rest; that is not the place to get it. We need to re-educate what a hospital is for but we also need to have alternative levels of care for them to go to. So if granny, aged 92, isn't managing at home and they have been struggling desperately and all of a sudden they cannot cope anymore and come to emergency then the only option I have is to admit granny to the hospital until we can find a nursing home bed. How silly, but I don't have any alternative. We need to engage the public a lot more and get them to understand what a hospital is for.

To be fair, the public is very forgiving of our health system. Some of the things that happen in emergency departments you would find hard to forgive, and I am part of the system that perpetuates that. The lack of privacy, for example, when we are overcrowded. I am discussing people's health and someone is sitting right next to them. I can't do it privately because I have no space. There is the system where I send someone home who is going to die of metastatic cancer - with no answers; the system where I have to send granny home because I have no beds and they just have to manage. It is very difficult, yet at the same time there are those people who are very good at manipulating the system so that they do get people who do not need to stay in hospital.

Also, when they are in a bed it is sometimes very hard to get them out of that bed, partly because they feel they don't have anywhere else to go to or they do not feel supported. We really do need to educate that community. For example, if we were going to get thrombolysis done by the ambulance I would start the education campaign months and months before I started it.

Mrs SMITH - Who should start the campaign, who should educate the community? This is our difficulty. This morning we had a very strong physician who said this State needs three hospitals. That is one of the first times I have heard a medical person of repute enter the public debate because they are usually too busy being the physician and the doctor et cetera. The community do not listen to the politicians. The community looks on the medical profession as people with very high esteem for the right purposes because they have confidence in their physician. Yet we do not get a medical stream that comes out and tells our community, 'No you cannot have that because if you want that service you need something different'.

Dr RUIGROK - Medical people have to play that role in education. I had a patient who came to see me the other day. I spoke with him for an hour and a half because he was concerned about the way his heart attack was treated. There is a long story to it. He said, 'Why haven't we got a cath lab at Latrobe? Should I be lobbying my politician for a cath lab in Latrobe?'. I said, 'Absolutely not, because you need to do a certain number of caths a week to stay in tune and we do not have the casemix for that. Would you like someone who has only done five caths in the last year to operate on you? I certainly would not; that would be dangerous!' He finally got some understanding that you cannot have highly specialised services in every little town.

Ms FORREST - I have this discussion in my office with my constituents every week, exactly the same discussion, and they do not take notice of the health professionals, unfortunately. We had medical professionals standing up at the Mersey debate trying to have their voice heard. They were not reported in the paper; only the other side of the argument was reported. Well before I was a member of parliament I was a nurse and a midwife trying to have the same debate and I was shot down by my colleagues as well as by community members in the Mersey end of the region. People do not listen to anybody if they do not want to hear what they have to say.

Dr RUIGROK - That is true, but you have to give something first. If you said that you were giving Mersey a specialist role in something -

Ms FORREST - It was how it was presented that was part of the problem.

Dr RUIGROK - And also provide a service. What we are here to do is provide a service for the community - you need the right service for you. You need to have emergency care when you need it and you need to have the right people operate on you when you need that operation and we need to make sure that our practitioners are looked after. You do not want someone tired, embittered and cranky operating on you when it is critical for you.

Ms FORREST - Correct.

Dr RUIGROK - I think it needs to be a partnership between the politicians and the medical people. I have met some dinosaur doctors down here that I thought had died out. Fortunately, they may be retiring soon. There are some attitudes down here that I never expected to come across in real life, but I think that is changing. In the north-west you have Gershu Paul, the Medical Director, you have Michael Buist, the new medical person, and you will be getting a whole bunch of new people in, people who have worked in other States and other countries who have a different view who are there to be able to provide that education.

Brian Doyle who is the Director of Emergency at the North West Regional Hospital is in the paper every second week - I think he is a media fan -

Ms FORREST - Media tart he is called.

Dr RUIGROK - Yes, that is right, a media tart who spends a lot of time educating. We single-handedly dropped the number of flu presentations by Brian's and my putting a piece in the *Advocate* saying, 'If you have the flu this is what you need to do'. People will actually read it. You can actually use it to educate the public. I would love to do a weekly thing of 'What's in our ED today. Let's tell you about croup. This is what you do for it. This is when you present'.

CHAIR - Marielle, we are getting close to running out of time. Are there any other issues that you have not touched on at this stage that you would like us to know in accordance with our terms of reference? You have been very interesting and I have let it go a bit.

Ms FORREST - It all relates to emergency medicine.

CHAIR - Yes, it does.

Dr RUIGROK - I have covered most things. I think that no matter what you do, often we cut beds in hospitals in order to save money. If you cut beds in hospitals in order to cut money you are going to have to spend it the Emergency Department to increase your capacity so you are going to have to spend it anyway and you may as well look at the best way of doing it. I actually think consultant-led admissions, where the GP rings up the consultant who says, yes, admit straight to the ward, actually is a much better way. It is a multi-entry point system for certain things, with consultant-led conversations about what needs to be done. I think that is very important.

I think we need to get the transport right. I think we certainly need to look at how we transport people around the State and improve that service remarkably. I think it is very underdone here. We need to really look at nurse practitioners and encourage that here.

If we do that we will provide very good nursing structures for our nurses to stay here because often when you go up the nursing structure tree you end up going out of clinical nursing into administration and that is just rubbish. A lot of nurses want to stay clinical and we need to have a pathway for that, too. I think we need to get less eight to five Monday to Friday and more eight to eight Monday to Sunday in a lot of different things. I think that requires extra staffing and it all has a cost. A specialist working on a weekend is expensive yet I -

CHAIR - We had evidence given to us earlier this morning that we need to think more 24/7 within the hospital system.

Dr RUIGROK - I also think buying expensive equipment and then not using it is completely stupid. For example, a stress test machine was bought for the North West Regional Hospital for $100 000; they use it two days a week. Why? For the sake of a registrar worth $80 000, you could have it five to seven days a week. Why are we doing it?

Ms FORREST - There must be a need for it with our history up there.

CHAIR - There is a need for it.

Dr RUIGROK - Absolutely and, oh, we cannot have it more than two to -

Ms FORREST - We are the fattest, biggest smokers -

CHAIR - That is what you are saying, that there is a need for it but you cannot use it.

Dr RUIGROK - It is just stupid. We also have a lot of respiratory disease, COPD. I am trying to set up at the moment a pulmonary rehab clinic in the north-west, similar to what they have in Launceston, which is fabulous. That cuts your COPD admissions down by 30 per cent in five years. Most of our admissions are COPD. A 30 per cent reduction in that, plus a reduction in length of stay. Our average length of stay of COPD at the Mersey is 12 days. The national average is, I think, seven or eight and that can be reduced to five if you have people in pulmonary rehab. Just look at the bed days you could save there.

We need to start putting things in place. We need to really educate the people on smoking, teenage pregnancies, obesity, heart disease and lifestyle - long-term things, as well as dealing with the tsunami effect because I am seeing a lot of people now, aged 15, weighing 120 kilos, smoking cigarettes. We are going to be dealing with those in 40 years' time in our hospital system.

Ms FORREST - They are probably on the pill as well, if they are girls, just to add another risk.

Dr RUIGROK - I thank you for asking me down. I don't know how you got my name. I don't know who mentioned it to you.

Ms FORREST - We have ways and means.

Dr RUIGROK - I am sure you do.

CHAIR - We can thank one of our members.

Dr RUIGROK - I could talk about investing in rail to cut the road deaths and to improve our transport. The road deaths are just phenomenal; I am just appalled by that. I think it is a combination of things - alcohol, lack of other transport options for people. In Canberra, whenever I saw a patient in a car accident, there was almost never any alcohol involvement, almost never. Here, almost always alcohol is involved. I think it is education and just the culture of you do not drink and drive versus 'It's all right, mate'.

Ms FORREST - We need to change people's attitude. We need to change the mindset of people who have a drink and drive because they think they will not be caught, to deciding not to drink because it might affect their judgment. If we cannot change that mindset, and I do not think we can because people do not think that way, we need to change the mindset to I do not think I will have a drink because I will get caught.

CHAIR - Marielle, is there anything else, just in conclusion?

Dr RUIGROK - If you are thinking of reallocating funds, you need to do something for IT.

CHAIR - Evidence has come out at this committee on the IT system that they have or are looking at and considering changing, so that is a good comment.

Thank you very much for your contribution and for selecting Tasmania as a place to live and to work. We are going to be so much better off because of that.

THE WITNESS WITHDREW.