CHAIR - Welcome to our committee hearing today. Andrew is online and Emma is here in person. It's lovely to have you here.

Just by way of procedure, everything you say today is protected by parliamentary privilege while before the committee but that may not apply when you leave this room. It is being recorded and it is part of a public hearing. It will be published on our website at a later time. Anything that you think is confidential you can make that request to the committee and the committee would consider that and then that wouldn't appear in our public information. It's all being recorded.

Do you have any questions before we start or are you okay?

Ms THORNLEY - It is worth noting I am unfamiliar with this process.

CHAIR - As most members of the public are. I would be happy if you want to use first names. Our names are in front of us, if that makes you feel more comfortable too.

Sarah is the other member who's just come in who you may not know. Nick's online, as we said, and Mike Gaffney and Bastian Seidel are also here.

We invite you to make the statutory declaration first. Then you might like to make some opening comments. We acknowledge that your submission was sent back in March and there's been a significant passage of time and there may be some change and you might like to elaborate on that.

Ms EMMA THORNLEY, PARAMEDIC, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED. **Mr ANDREW McDONELL**, PRESIDENT, AUSTRALIAN COLLEGE OF PARADEMIC PRACTITIONERS (VIA WEBEX) WAS CALLED AND WAS EXAMINED.

CHAIR - Andy, you don't need to swear because you're not in Tasmania, are you?

Mr McDONNELL - No, I'm not at the moment.

CHAIR - If you'd like to introduce yourself and then I'll get Emma to make her opening comments.

Mr McDONNELL - I'm paramedic, Andrew McDonnell. I am the President of the Australian College of Paramedic Practitioners. I have a background as a mobile and intensive care paramedic. I've also completed a physician assistant program and presently I work as a nurse practitioner in private practice. My job today is to assist Emma where possible. Emma will be the lead. If Emma needs some assistance then I'm here to help.

Emma's a proud Tasmanian and has done some amazing work servicing the people of Tasmania who are in remote and rural areas where normally they wouldn't have outcomes. She'll talk about the paramedic practice and the concept in details.

Ms THORNLEY - I grew up in Dover down south so I am most definitely a local. I have been employed by Ambulance Tasmanian since 2001. I am a physician assistant with a master's qualification through the University of Queensland School of Medicine. I am a post-

graduate lecturer in paramedicine at UTAS. I am the first paramedic practitioner to be employed in Tasmania. I practise as part of a multi-disciplinary team alongside RNs and nurse practitioners, paramedics, GPs and rural generalists. Hopefully, soon I will be going to Ouse with that team which, believe it or not, represents a career highlight for me.

Twenty years of working in Tasmania as a paramedic has given me some keen insights into how people in the community really live and how things have been on a trajectory towards crisis since I began my career in health in 2001. This is the unique thing about paramedics: we spend all our working days in and out of people's homes and lives so we have a unique insight into the impacts that the failures in the health system have on the Tasmanian community.

I'd like you to be aware that paramedics are the only health professionals who are educated and trained to practise exclusively in the community. We are not trained to practise in hospitals or clinics. If we were to shift to that environment we need the extra education. We are trained to practise in the community.

The college believes we are an underutilised resource for understanding the issues and developing the solutions. Some of the inescapable truths that paramedics have recognised are things like ramping, which is a complete waste of resources, it is dangerous and it is not patient focused. Bed block and ED overcrowding are largely the result of patients not having access to appropriate and timely care in a community.

For the same reason ambulance callouts are predominantly non-emergency cases. Anecdotally and statistically we know that about 90 per cent are non-emergency cases. Most concerning for me is that many of the critically unwell patients whom we do attend are only in that situation because of the lack of early intervention in the community. It was missing. This is especially true in rural and remote areas. Associate Professor Ruth Stewart, whom we follow keenly as the Rural Health Commissioner says,

[TBC]

> Rural and remote people have often been wrongly described as stoic. They soldier on with ill health until they can't go any longer.

Paramedics will tell you Ruth is correct.

Any paramedic can also tell you where a majority of the issues originate from. We understand the population demographic has higher needs for primary health care services. We know there is a lack of after-hours services because we fill that gap. There's a lack of bulk-billing services; there is a lack of primary and urgent care centres, facilities and infrastructure. There is a lack of transport options, even public transport in rural areas is an issue for health. Extended waiting times to see your own GP goes sometimes into weeks. If you think you're going to go to another GP, think again because they're not taking new patients.

Worth noting, as if this doesn't sound disastrous enough, these issues are compounded if you are, for example, a patient who is a single parent, you're homeless, have a disability, victim of intimate partner violence, you're culturally and linguistically diverse, you have low literacy skills or you're Aboriginal. Paramedics see this every day. We at the College of Parademic Practitioners advocate for paramedics being able to gain an appropriate education to be able to deliver the knowledge and skills that have been identified as most lacking in our rural

communities. We understand this community; we live and work locally, and we have done the work to make ourselves ready to be part of the solution.

The College did not do this purely on a whim, we did it because we were following recommendations from the Government. Multiple health workforce reform reports have made the recommendation that one of the solutions is to upskill existing health professionals to do more in the communities where they live and work, rather than relying on bringing in locum doctors for short periods at great cost.

This sensible, affordable and sustainable recommendation for upskilling existing members of the health workforce has never been considered for paramedics up to this point because we have been routinely excluded from discussions, reviews and planning for the health workforce. Even yesterday I noticed the Health minister was interviewed and commented that he was in discussions with the AMA and the ANMF but there was no mention of any discussions with anyone from paramedicine.

There is a serious misconception that paramedics just work in ambulance services; that ambulance and paramedic are one and the same. This is not the case. Ambulance is an employer and a paramedic is an independently registered health professional. We have been registered with Ahpra (Australian Health Practitioner Agency) since 2018. We now wish to have the same legislative and government support that other Ahpra registered professionals have to be self-determined and have options about who we work for, what career path we choose and where we want to practise. That way we can evolve as a profession to do what we do best and to serve our community.

In 2018 a paramedic colleague of ours from the north-west coast, Simone Haigh, initiated a senate inquiry into the mental health of first responders. It made multiple recommendations on how to improve the alarming findings from the inquiry. One recommendation was to develop structured career pathways for paramedics to move away from frontline emergency services delivery. This is in line with all the evidence suggesting it is not a career where longevity is healthy.

Given the gaps in the health workforce and paramedics' deep understanding of the issues facing everyday Tasmanians, we at the college believe it is a logical career path for paramedics to be able to gain an appropriate education that prepares them to work in multi-disciplinary teams delivering primary health care in the community.

The college advocates for innovative alternate models of care where health professionals come from backgrounds as diverse and as local as our patients. The international experience from adding paramedic practitioners into multi-disciplinary teams alongside nurse practitioners, GPs and other health professionals has shown that it creates a flexible workforce from differing backgrounds but with complementary strengths who can effectively and adaptively respond to the ever-changing needs of patients in the community.

The current model for health delivery here in Tasmania along with outdated legislation and a lack of government support and recognition for paramedics as independently registered health professionals is preventing paramedic practitioners from even being considered up to this point. The college has developed a robust career structure, education plan and professional standards for paramedics to become effective, affordable and sustainable primary healthcare providers here in Tasmania and nationally.

Our aim is to futureproof ourselves professionally and this means we are not designing a stopgap bandaid but a short and long-term plan to become part of the broader health workforce and to deliver the right care where it is most needed.

Thank you very much for a seat at the table.

CHAIR - Thank you Emma. We are hearing from a number of people involved in paramedicine and you are all providing a pretty compelling case. A couple of questions I would like to follow up from your comments there. With regard to when national registration first came in and I remember reading through the great tome of the national law. There was a lot of information in it but it did not cross my mind at that time that this would have this impact on people employed in and working in paramedicine.

I guess the assumption was made that if as a registered nurse, a midwife, I could work in the ways that I could work that paramedics could too.

Do you know whether there was any discussion at that time or whether it was even raised that this would need, or should lead to amendments to our legislation, our Poisons Act and also to the federal legislation regarding the NDS and PBS?

Ms THORNLEY - There is an excellent paper by Michael Eburn who is an associate professor at ANU and a lawyer. He had a very supportive emergency services blog where he would take emergency services issues and give legal interpretation on them. When he was doing that, back before we were registered, he wrote a really good paper and it does discuss the fact that this could be an issue. The states are legislating to keep paramedics in ambulance services whereas that seems at odds with becoming an independently registered health professional. It is important to remember that the legislation was in place before we were registered. When we were not an independently registered health professional -

CHAIR - You mean when the Poisons Act was in place?

Ms THORNLEY - The Poisons Act, Ambulance Service Act and there are various others where it could be considered we should be included. They are the two main ones, the Poisons Act and the Ambulance Service Act. Actually, the Ambulance Service Act was changed at the time before we were registered to protect the paramedic name title, so in the Ambulance Service Act it actually does talk about how essentially you cannot call yourself a paramedic unless you are employed as an officer of the ambulance service.

CHAIR - Which was designed for the right purpose. I remember dealing with that legislation too.

Ms THORNLEY - At the time, but that is the point. We became independently registered and that legislation is now significantly outdated and really impinging on our ability to practice.

CHAIR - With regard to the paper, I have forgotten the gentleman's name.

Ms THORNLEY - Michael Eburn.

CHAIR - Michael Eburn. If you could provide that to us it would be helpful but it did not gain any traction, obviously, because nothing occurred as a result, or did it in other jurisdictions?

Ms THORNLEY - I think everyone was so focused on the enormous task of gaining registration with Ahpra, and I think there was the assumption that when that happened governments, at a state base, would probably review their legislation. It's not until this point that I'm the first paramedic practitioner who has tried to step outside and I've gained employment. Then I've sat down with the doctors I work with and the business director and discussed my scope for practice, reviewed the legislation and thought, 'Right, I cannot practise effectively. I'm really restricted here'.

Even at the vaccination clinics I do, there's been an issue because whilst I am now legislated to provide a vaccine, because I'm not listed as a health professional under the drugs and poisons act it could be argued that I can't give adrenaline if someone has an anaphylactic shock. I've been giving adrenaline for anaphylaxis for 20 years.

CHAIR - Outside of the ambulance service?

Ms THORNLEY - Yes, I'm employed as an officer for the ambulance service.

Ms LOVELL - Thank you for your submission and for your opening comments. That's really helpful. In your submission you talk about paramedics being restricted by unfavourable legislation. What you're speaking about now, could you elaborate a little bit on that in how that affects and impacts on your ability to practise in Tasmania?

Ms THORNLEY - The first time I noticed it was at the vaccination clinics because the nurse and doctor that I was in a team with one day made a joke that, 'If an anaphylaxis happens to any of our clients today, we'll let you deal with it'. I was completely fine with that idea. I have no issue with being the anaphylaxis management team member.

Then I realised that we'd had this discussion a week earlier about what I can and can't do because of the legislation and I know that they changed legislation so I can give a vaccine. I had to check, because it's so complex - and I realised they also hadn't included adrenaline.

Ms LOVELL - Is that because when you're working in the vaccination clinic, you're employed by -

Ms THORNLEY - A private provider, not the ambulance service.

Ms LOVELL - Ordinarily, when you're operating as a paramedic with the ambulance service, you can do all of those things.

Ms THORNLEY - Yes.

CHAIR - In the vaccination clinic, were you engaged as a paramedic practitioner or a nurse practitioner?

Ms THORNLEY - I'm not a nurse. That was the problem for me because I could never go and do nurse practitioner. I'm not a nurse so I did physician assistant. The nurses who did

the physician assistant program with me, when we finished, they went and used their physician assistant education and became nurse practitioners like Andrew.

I thought, 'Oh, that's a good idea', except there's no model for paramedic practitioner so we built one.

Ms LOVELL - How many paramedic practitioners are there in Tasmania now?

Ms THORNLEY - I'm going to have to take that on notice because I think it might have changed even in the last couple of days. There's a few of us.

Ms LOVELL - Thank you. Can you talk us through the difference between an extended care paramedic and a paramedic practitioner?

Mr GAFFNEY - Sarah, on that, when you say a 'few', are you talking handfuls or under 10 or 15?

Ms THORNLEY - Yes, a small number.

Mr GAFFNEY - Not 40 or anything. Yes, small numbers. Sorry, Sarah.

Ms LOVELL - If you could talk us through the difference between an extended care paramedic and a paramedic practitioner.

Ms THORNLEY - An extended care paramedic was a model developed by ambulance services for ambulance services. It's an in-house trained model. They expanded their scope within the ambulance service to include some primary care delivery. A paramedic practitioner is a paramedic who has done a clinical master's degree so it's not a master's degree with half research, half clinical. It's a clinical master's degree to maximally increase their scope to deliver the knowledge and skills that are required.

The degrees that are available in Australia at the moment - Deakin is running a paramedic practitioner degree which is a clinical master's degree. We have several dual-qualified nurses and paramedics who've opted to do Nurse Practitioner General Practice Pathway. We've reviewed that and that's appropriate to give them accreditation as a paramedic practitioner. They can be dual-qualified, nurse practitioner and paramedic practitioner - I am not sure they want to, too many hats. In a nutshell, extended care paramedic is an in-house ambulance service trained provider designed for working inside the ambulance service. A paramedic practitioner can work anywhere, in ambulance, in a community clinic, in a small hospital.

Ms LOVELL - In a GP practice?

Ms THORNLEY - Yes, absolutely.

Ms LOVELL - Okay, thank you.

CHAIR - Running on from Sarah's questions about the impact of the legislation that currently sits, particularly with the Poisons Act and the Ambulances Service Act in Tasmania, how will that impact on you working in Ouse? You might need to describe your role in Ouse

and what limitations it would create. If a change was made to legislation, what would be permitted?

Ms THORNLEY - Initially, when we go to Ouse, there will be a period of doing a needs analysis with the community and existing providers such as the ambulance service and community nurses, to figure out how we can best suit the community. We are not coming in and saying, we are here, this is what we do, we are more hoping to look at what is the need and how we best suit that. Initially, I will not be able to do a whole lot clinically - unless I am directly supervised by a GP - which is fine and I love it, but that is not a sustainable model.

I am hoping to use that time to run quite a few education programs and start a collaborative relationship with the Ambulance Tasmania paramedics up there, so they can refer non-emergency patients who they would ordinarily take to hospital. We are hoping to be able to get them to refer them to us instead, at least for an assessment to see if it is possible to keep them in the community. At the moment, it is a bit unclear exactly what my role will be in Ouse. If the legislation does not change, it is likely it will be quite limited.

CHAIR - If it does change, what would you do?

Ms THORNLEY - I will be able to discuss my scope of practice with the GPs and the business manager and based on the needs of the community figure out what scope I need and if there is anything missing. I am planning on doing a few chronic disease management courses because that is an area I need to refresh in. It has changed a lot since I was at uni. I am hoping I will be able to deliver some chronic disease management clinics, as well as seeing walk-in patients who do not have an appointment, patients coming in with chest pain and asthma.

CHAIR - Things you would attend to as a paramedic.

Ms THORNLEY - Exactly, yes. If we get the emergency walk-in, the GPs and the nurse practitioner do not have to be disturbed because that would be one of my roles.

Ms LOVELL - You will be employed privately there, is that right?

Ms THORNLEY - Privately, yes.

Mr GAFFNEY - You mentioned the Ambulance Service Act 1982 and the Poisons Act 1971. I am aware there are several pieces of legislation. Are any of those real game changers and how many are there? Do you or Andrew have a list as people listening would be appreciative of that.

Ms THORNLEY - I think Andrew has provided a list.

Mr McDONELL - Yes, the game-changer acts we see are, as mentioned: the Ambulance Service Act 1982; the Poisons Act 1971 and its regulations; the Mental Health Act 2013; the Births, Deaths and Marriages Registration Act 1999; the Public Health Act 1997; the Human Tissue Act 1985; the Evidence Act 2001; and the Workers Rehabilitation and Compensation Act 1988. They are the major acts we see. However, other acts, such as Births, Deaths and Marriages et cetera are minor adjustments. The key acts are the changes to the Ambulance Service Act and the Poisons Act to allow a paramedic and a paramedic practitioner working in primary care to be able to work to their scopes of practice.

Mr GAFFNEY - When you have said significant changes, the first two acts would have significant changes, the next five or six acts would just be consequential changes to it and not as significant.

Mr McDONELL - Yes, correct.

Mr GAFFNEY - When it said significant changes, it looked as though it was to all eight.

Ms THORNLEY - No.

Mr GAFFNEY - No. It would just be the main two.

Mr McDONELL - Yes, but the other ones will need the rollover changes, if that makes sense. For example, with the Workers Rehabilitation Compensation Act a paramedic and a paramedic practitioner and primary health care would be needed to be put in as a person who could sign off an injured worker, for example. It is only a small addition to the act.

Mr GAFFNEY - Okay, thank you.

CHAIR - That can be done within a major reform - a reform of the Public Health Act as consequential amendments.

Ms THORNLEY - When we are talking about the Poisons and the Ambulance Service Acts, everybody keeps saying significant changes. It will mean a significant change for me as a paramedic practitioner trying to practise, but it is actually not a big change. When my lay person non-legal interpretation looks at the Poisons Act, I see all these other health professionals listed who are allowed to carry the drugs they use within their scope of practice and provide them to patients - it even lists podiatrists; it does not list paramedics. It is actually really not a big change.

Mr GAFFNEY - That is a good point. Whilst it is significant to you, it is not at this stage majorly significant to the actual act.

Ms THORNLEY - Why are we not considered a health professional? If a podiatrist is a health professional, a nurse is a health professional, why are we not a health professional? We do a health degree and are registered with Ahpra. Why is the only time we are mentioned in the legislation in the Ambulance Service Act? In terms of the Ambulance Service Act, the purpose of it should be to protect the ability of the government service to deliver emergency ambulance response in the community. It should not be to restrict a workforce who are independently registered, so they cannot work for anyone else.

Dr SEIDEL - I think you make a really good point because in your submission you say you are the forgotten profession, but you are actually artificially held back and there is no reason for that. Nationally, you have a national health commissioner, the past one was supportive of the model. The current one is supportive of the model.

Ms THORNLEY - Correct.

Dr SEIDEL - The Paramedic Board of Australia says there is no impediment for you to work as common practice We heard evidence from Professor Ray Bange yesterday stating half of the primary graduates are disappearing somewhere completely different. You have given evidence the extended care paramedic model is an inhouse model that probably does not even work; it is probably not even effective and if you want to leave the Ambulance Tasmania Service then the qualification is gone because it is only valid whilst you are an employee there. In a situation where we need all hands-on deck there is no cost solution here to the Government to allow qualified health care practitioners to work in health in the community. How many more boxes can you tick? It is not sensible, is it?

Ms THORNLEY - That is why I do not understand why we are not getting a seat at the table to be part of the solution. We do not have the whole solution, but we as paramedics over the years of experience practice - the Board of the Australasian College of Paramedic Practitioners - I did a vague count up the other day and between us we are over 200 and something years of practice. It is ridiculous. We are very experienced, we really do understand the issues and have not done this flippantly or on a whim as we have worked with lots and lots of organisations and key stakeholders. We have developed a really thoughtful career structure for paramedics and it will not be the only one, but we focused on the primary health care structure first because that is the one we see as the most vital for the community.

Dr SEIDEL - You mentioned the University of Tasmania currently does train paramedics and you mentioned you are also employed by the university as a senior lecturer. Do you think there is an interest by the university to actually offer a masters course similar to what Deakin University is currently offering, considering we already have plenty of graduates and there seems to be demand for qualification? Wouldn't it be attractive for the university to say, we already have the first pathway, paramedicine, let's add a masters with a similar model to what Deakin do? Would that be unique for Tasmania and a great story to tell?'

Ms THORNLEY - Deakin were amazing stepping forward first. But I feel at the moment Tasmania is the 'little engine that could'. We could really create a model here, with the education and the workforce planning and the paramedic organisation finally being recognised as a valuable member of the healthcare workforce. We really could do something which might have an impact nationally. I can't comment on the university's stance at this point except to say that they are aware that in paramedicine at the moment they are producing more university graduates than there are jobs.

Dr SEIDEL - Within the Tasmanian ambulance system?

Ms THORNLEY - Yes, absolutely.

CHAIR - Even though we can't get the positions filled in my electorate.

Ms THORNLEY - The university produces all these undergraduate paramedics. They need to do a transition to practice internship in an ambulance service. If they don't do that within two years they need to reconsider their degree and probably do another one. They often go back and do nursing or they go on to another profession altogether so we lose them from health. So, there's this waiting room that's packed at the beginning of the paramedic career. They're having trouble getting in. Then when they're in the rates of being injured, psychologically and physically, are really high. Once you're injured your choices are: if you want to continue practising in health you either have to go back and study another degree in

another field of health altogether; or you leave and move on away from health; or you stay in the ambulance service if you want to continue to practise clinically, the very place that injured you. There's no way to move out.

What we're doing here is pulling the plug at that end to enable paramedics with experience and who've served their time there and who choose to decide to forge a career in primary health care to be allowed to move out, gain the education they need and move off into the primary health care workforce where it's so needed. That's also going to free up space in that environment for graduates to come on board.

CHAIR - I want to follow up with a couple of questions. We had the AMA across the table yesterday and they indicated they felt that in the areas like Ouse or other small communities they'd be better off getting more GPs. We know there's a shortage of GPs so it's a bit of an oxymoron.

It seems to me that there are some of the barriers to this occurring. One is the legislative barrier, obviously. I won't say it can be easily changed but it can be changed. But there's also the acceptance of other health professionals within this space. I'm very familiar with turf wars whenever midwives talk about practising across their full scope at times. If you remove the legislative barrier, where could other barriers be to this? You did say you have to work under supervision of a GP.

Ms THORNLEY - Yes, at the moment. Absolutely.

For a very long time we've heard the argument, 'We just need more GPs'. How's that going for you? I don't know; it doesn't seem to be working overly well. I know that we've put a lot of money into it and waited quite a long time for that to be the solution and it doesn't seem to have worked. So, let's try something different.

On the ground, at the coalface, I've never found any opposition, right from the time I was a student physician assistant doing placements with GPs: I did a placement at a practice where Bastian worked and there was never any opposition. There was curiosity but I never felt that there was opposition. From the coalface, I can't comment on the opposition.

Politically, you mentioned the AMA. Since developed countries had governments that developed health systems, the place that originally they sought most of their advice from, on what that health system should look like, was medicine. I would argue now, today, especially in Tasmania, why is the medical workforce more experienced, qualified and knowledgeable to comment on what the Tasmanian community needs as opposed to paramedics who actually live and work and are trained exclusively to practise in the community?

Everybody has a voice and everybody can contribute. I don't think in terms of the planning that one health professional actually should have the one-size-fits-all answer. I think everybody can contribute to the solution.

CHAIR - On that front, have you or the organisation had direct communication with our Health minister about this? He said he was out in the media yesterday and did not mention paramedics at all. Have you tried to get meetings? Have you had meetings and how have they gone?

Ms THORNLEY - There was no opposition to the model. We made some suggestions for a working group for trials but we unfortunately not had any follow up at this point, but there has been a lot going on so that is understandable. But, yes, the Health minister is aware of the potential for paramedic practitioners.

CHAIR - He will be before the committee at a later time, so no doubt we will ask him about that.

I have had a chat with Bastian as a GP, and you mentioned yourself the study that was done showing the quite horrifying impacts on paramedics' physical and mental wellbeing that have occurred. If a person is working as a paramedic just dealing with really serious and often tragic circumstances, in small communities it is often someone they know so that is even more traumatic, if it can be. Do you believe if paramedics could work across a broader scope and not just deal with that, but also have some downtime where you deal with people who are not critically ill but needing care, that it might make the longevity of the profession more sustainable?

Ms THORNLEY - Absolutely. When I did my physician assistant master's degree from 2010 to 2012, I thought I was going to find it completely exhausting studying and still continuing to work part time in ambulance. But what I found was that working outside the silo of ambulance and working in multi-disciplinary teams with doctors and nurses and nurse practitioners and nutritionists and physios was energising. I realised how rewarding it was. It actually made going back to ambulance easier. Because I could not get a job as a PA, I had to go back to ambulance. What I found immediately was that the 90 percent of patients who I had been seeing who were not an emergency were really interesting. I had never had any education to deal with them clinically before. They had been a bit meaningless, but suddenly they were interesting. So, it really changed my whole outlook on practising as a clinician, even in ambulance. And, it was very healthy.

So, I think futureproofing paramedics so that they can practise in ambulance but also for whatever period of time and for whatever reason, whether they just choose a career change or they get injured and it's a rehabilitation period, being able to step outside the frontline coalface of emergency service delivery, and shiftwork and constant pages, into a really supportive clinic environment in the community, is a no-brainer.

CHAIR - We are just about out of time. In a minute we can come to you Andrew, if you want to make any closing comments. Emma, you might want to make any closing comments and perhaps even note whether there might be some national examples that you might be able to use that will illustrate a model that we could look to.

Ms THORNLEY - We have designed a model. When you talk about a national model, are you talking about one that we have designed or one that already exists somewhere, like the UK?

CHAIR - Either.

Ms THORNLEY - Andrew is probably best situated to talk about how paramedic practitioner operates in the UK. And, that is probably the best example, because we do not currently have one here in Australia. We have designed one that we think, based on what happened in the UK, is going to work really well here and it is one of the roles of the college,

we are always happy to share that information. There are things that we can send you to include if that is possible.

CHAIR - Yes. If you think there's something helpful to the committee, please feel free to send it.

Ms THORNLEY - Andrew, do you want to talk about the paramedic practitioner model in the UK and what it looks like, how it works and why it works?

Mr McDONELL - I can talk about a couple of models. In Victoria there's a business called HMS Collective. They're a community-based organisation which are utilising paramedics in community care. They've only started so it's about week 40. I do have to declare an interest because I'm the chief executive officer of that organisation.

Essentially what we've found is that it's the paramedics coming into the organisation who have filled a major gap of preventative health and preventing people going to hospital. It is a multi-discipline team with community paramedics and community nurses. It also has allied health and the end point is to keep people in primary health care instead of in an ambulance or going to hospital.

That's a beginning organisation. What we've realised is that although community paramedics are wonderful, their skill base is not high enough. If we had access to paramedic practitioners who could go out, fill in the prescribing and do the home visits from GPs that would enhance the service tremendously.

In my practice at the moment, I spend a lot of the time going out with the paramedics and providing prescriptions et cetera and bringing people back to primary health. We've worked out in our first 41 weeks an average of about 41 hours a week of ambulance call-outs have been decreased. If we probably had paramedic practitioners with prescribing rights working with GPs, that would probably even increase further.

In terms of the UK, they've had the concept of paramedic practitioners for about 20 years. In the last two years, they've become prescribers and able to order tests et cetera. They work for ambulance services and outside of ambulance services. The model that's used over there is that the paramedic practitioner employed by the National Health Service either in the clinic or by the ambulance work from a GP clinic. They see people in the GP clinic and the ambulance service will refer a number of patients to that clinic which the paramedic practitioner will go out and see in their home. With the GP, the patient or the person will become part of that clinic.

They work extensively and very closely with nurse practitioners in the UK and between nursing and paramedicine they bounce off each other beautifully with the GP overseeing. The service seems to work extraordinarily well.

You'll notice that in our submission, we did quote in the UK that approximately with one paramedic practitioner introduced into aged care supporting the team, an additional £42 000 was saved per person that a paramedic practitioner saw.

In terms of financing, in the UK the paramedic practitioners are self-funding. They've decreased the burden on the health service in terms of funding instead of increasing it. The

key model about the UK is ambulance services change from a monopoly which is happening here. There are about 5000 paramedics working outside of ambulance services now.

The models have changed. Paramedics are pushing in. There was a recent story on television which was shown over here about community paramedics which interviewed two paramedics who work in GP clinics in Western Australia who are now doing chronic care. The legislation over there is different and they can use some medication appointed by the GP.

The key point it comes to is, one of the biggest gaps that paramedic practitioners internationally are feeling are the home visiting models and keeping people in primary care. In Australia, particularly in Tasmania from my talking with people, because GPs are unable to go out and visit people in their homes, the ambulance service becomes the home visiting service.

The problem is that patients end up in a hospital and there's no real close interaction between GP clinics and the ambulance service. They do their own things, hopefully that will change in future. The concept is that gap, which is missing, which is often the in-home care at a high level, is not being picked up and that's where paramedic practitioners can pick that up very closely with nurse practitioners. Is there anything you'd like to clarify about what I've said?

CHAIR - No, it's pretty good, thank you, it's pretty clear. Bastian had one question.

Dr SEIDEL - For the record, because you mentioned paramedic practitioners and paramedics working in GP practices. Currently, neither are part of the Commonwealth Workforce Incentive Program. Would you like to see that change so those positions are actually funded? It's a capped program. There wouldn't be any extra cost to the Commonwealth or the state, it would just allow GP practices to attract the workforce they want and that might include paramedics or paramedic practitioners.

Ms THORNLEY - And nurse practitioners, more readily as well. We've been working quite closely with a lot of nurse practitioners here in Tassie and, goodness me, the modelling they do to be able to practise with the limited number of billing items available to them is interesting.

Dr SEIDEL - At least they are part of the program.

CHAIR - Paramedics are not.

Ms THORNLEY - Yes, exactly. We're one step behind them.

Mr McDONELL - The colleges recognise that. There is a Commonwealth review at the moment. We've submitted to that review and we've also written to the federal health minister, the rural health minister and one other. We've asked to be included on that list. As you rightly say, if that was the case there would be no additional costs.

The other thing that is bizarre about the Commonwealth is that the Department of Health has defined paramedics as allied health, saying that paramedics meet the same criteria as other health professionals such as physiotherapists, osteopaths. They list chiropractors, they list podiatrists, et cetera. We meet the same criteria and same definition but Services Australia are continuing to decline to allow paramedics to access the MBS even though the definition is the

same. That's a little battle. As an employer of paramedics, it's completely frustrating because if we had access to the incentive plan as well as access to the MBS it would make a significant difference to the community we serve.

CHAIR - Thank you. We are out of time, Emma, but I will give you the opportunity to make any closing comments. The evidence you have provided today has been very helpful.

Ms THORNLEY - I have one point I want to make because I don't think I answered particularly well when you asked about the opposition and where it is coming from. You mentioned the AMA. I believe that it is not because there is a real issue but because there is a lack of understanding. Two reasons I believe that are because, in this review, the AMA made a submission and one of the issues they talked about was GP succession planning. I know we could extend GPs in rural areas for much longer and we would have much more success keeping them if they were better supported. In terms of succession planning, paramedic practitioner would not take over from a GP but support them so much better that hopefully, succession planning will be easier. And the other reason there is a lack of understanding from the AMA was recently, they did an article on telehealth and said they had this great plan for telehealth which seemed really good, except part of the plan is they will be in the office and do telehealth. If the patient needs a physical examination done, they will get ambulance officers to come and do the physical examination under their direction over telehealth. As I read that, I realised they do not understand there are paramedics like myself and every other paramedic practioner in the college, who would be more than capable of doing the physical examination and the advanced history taking and the clinical reasoning and diagnosis and realising if it is actually something outside of our scope we need to refer. We can actually do that, we do not need to just turn up and be guided through a physical examination. There is a lack of understanding.

CHAIR - Do you have established clinical guidelines for referral and consultation?

Ms THORNLEY - Not yet.

CHAIR - Not yet, yes. I know midwives do.

Ms THORNLEY - Yes.

CHAIR - Yes. Okay. All right. Thank you very much.

Ms THORNLEY - Thank you.

CHAIR - Yes, I really appreciate your time and providing very succinct and clear evidence to us. Thank you.

THE WITNESSES WITHDREW

The committee suspended at 9.51 a.m.

The committee resumed at 9.54 a.m.

Ms JUDY DEW CEO, and Ms **EDWINA CUMMINGS**, CHIEF PROGRAM OFFICER, GENERAL PRACTICE TRAINING TASMANIA WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED

CHAIR - Welcome both of you to the hearing. We have your submission and we appreciate you have put the time in to provide that and the update after we had to stop for a while. This is a public hearing, it is being recorded by *Hansard* and will be transcribed and put on our website as a public document at a later time. What you say while you are here before the committee is protected by parliamentary privilege, but that may not apply when you leave. If you have something of a confidential nature you wish to discuss you can make that request to the committee and the committee will consider that but otherwise, do you have any questions? I assume you have the information about appearing before a committee? Do you have any questions before we start?

Ms DEW - Not at this point.

CHAIR - I will get you to take the statutory declaration in just a moment. Nick Duigan is one of our members and is on the line; Sarah Lovell; Bastian Seidel; Ruth Forrest and Mike Gafney. After you have taken the statutory declaration you might like to introduce yourselves and make some opening comments and refer to your submission further if you need and then we will have some questions.

You are aware of our terms of reference and you do not have to talk about all, just the ones you are particularly interested in or have a comment in would be great.

Ms DEW - Thank you for the opportunity to present today. I have a short opening statement and then we are happy to take questions.

As you would have read, General Practice Training Tasmania is the state's only college-accredited provider of GP training. We are a grant-dependent NGO and not-for-profit organisation whose main purpose is to provide vocational GP training and education to doctors under the Australian General Practice Training Program. Each year, we recruit 30 to 35 doctors into this program and with the support of GP practices around the state, place a similar number into community general practice so they can complete training terms.

At any one time, we have at least 120 GP registrars in training around the state and in 2020 about 18.4 per cent of Tasmanian GP FTEs were registrars providing clinical services on the ground. Very importantly, around 75 per cent of these GPs stay in Tasmania when they have completed their training with our organisation and attained fellowship with their respective college.

As we have written in our submission, the federal government is seeking to introduce a new system for training GPs from 2023 and we are very concerned about what this might mean to GP availability in Tasmania in the near future. Even at this stage it is not clear how this new system will work. The year 2023 might sound like a long way away, but March next year in the ordinary course of events we would be in market seeking applications for the following year's program. As the model for 2023 is not even close to being finalised at this stage, it is extremely difficult to see how successfully the GP training course can be run in that year. We

see a very real risk that applicant numbers next year will be extremely low due to the uncertainty about the training program they will be entering into and potentially low in subsequent years until the new college-led programs have been tried and tested.

We are also concerned GP training funding could be fragmented into different funding buckets under this new system rather than the current end to end regional training organisation system we have currently running.

This potential separation of workforce need, assessment and placement distribution away from the colleges also adds to the significant risk. Under the training arrangements, regional training organisations have established networks and knowledge within their areas of distribution. We know our communities, our practices and we get to know our registrars very well. We have a necessarily complex process for registrar placements when it takes into account the community, regional needs, as well as practice and registrar need and we bring those together for the best outcome. Under these latest proposals there is also the risk any funding for Tasmania will be shared amongst other organisations and not necessarily controlled within the state.

Splitting the various aspects between multiple providers is also likely to lead to inefficiencies of delivery and perhaps not the best training outcomes. What we do know for sure is that if these changes go ahead in the timing currently proposed - so there's only about 16 months to have this all sorted out - it will upend GP training in Tasmania and cause significant dislocation and possible confusion.

As we know, GPs and their practice teams have been and continue to be under immense pressure. Many practices are reporting longer wait times than ever before. Staff are tired, the lack of certainty about training beyond 2022, including practices potentially needing to answer to two colleges or many masters, instead of one local training organisation has the potential for practices to opt out of training provision. This will be devastating for GP training, not only for the trainees seeking placements but also the practices, communities and future GP applicants.

In our view, building a whole new GP training program from scratch when you already have a system that is currently working quite well or very well and is very mature, particularly if it happens in the same time you are battling the biggest global pandemic that this century has known anyway, adds to this risk further. For these reasons, GPTT is calling for the federal government to defer the proposed changes until about 2025 to allow for proper consultation, detailed preparation work and for the worst of the COVID pandemic to have passed.

In conclusion, I would request that this committee takes a very close look at this issue which has potentially very serious negative repercussions for Tasmania's rural health system. Thank you.

Mr GAFFNEY - Thank you. You mentioned you'd like to defer it to 2025. Are you saying we'd like to defer it so it can go ahead then, or we want to defer it so you can reassess what the real implications or impact of this move might have? So are you using the pandemic and the stress as the reason to defer it? I get the impression that there's more to that than just deferring it, you want it to be reassessed and re-evaluated to see if it's going to suit Tasmania's needs.

Ms DEW - It's actually a national rollout as well, so it will affect Tasmania as well as other regions around the nation. Our reason for asking for deferral is not only because the impact of the pandemic is slowing this down; it's such a radical change than what was originally proposed I think in 2017.

We were advised by the minister Mr Hunt that GP training would be returned to the colleges and that was widely accepted. It's just the 'how' it was going to go about was changed, probably 12 months ago now, and rather than perhaps using organisations such as our RTO to still provide that training, the college has much more control over that and we were credited to provide their training anyway. It's now fragmenting the model but it hasn't been well consulted and it hasn't been well planned out yet. It's still being worked out how this new system will work and that's why we have been asking for more time for this to happen.

Mr GAFFNEY - My last question would be, nationally as a concern, how is that being handled? To whom are you presenting, because it's all right to come to our committee in Tasmania, I'd be interested to know nationally what's on the cards? Is each state asking for a deferral to 2025? Has that been an agreed position for all states and territories to go to that year?

Ms DEW - Yes, that has been a position that all of my organisations have taken - there are nine of us. We've also put in a submission to the senate inquiry as well, which has only been quite recently that it has closed. Yes, that is our position but we do accept that a transfer to college-led training will be inevitable.

CHAIR - Can I just follow up with that, perhaps from Mike's questions. As I understand it, other specialist training is undertaken by the relevant colleges.

Ms DEW - Correct.

CHAIR - You're not opposed to it being returned to the college? I think it was originally with the College of GPs, you're not opposed to that. You're not sure about the model and how that will be undertaken? Can you articulate that for us more then?

In your submission but also in your opening comments you talked about perhaps some of the fragmentation that will occur and potentially negatively impact on GP availability. I'm not quite seeing the connect here. There's a bit of information missing for me. Could you explain how that will cause those problems and whether or not you're opposed to it going back to the colleges in the first place?

Ms DEW - We're not opposed to the colleges taking back their training. We're accredited by the colleges to provide the training as they see fit and that comes back to the Australian Medical Board.

It's more about the 'how' and the change of model that's been proposed in a very, very short time frame. At the moment, coming back to being in market by about March next year to try to attract doctors to come into the program for general practice, we know exactly what their three-year training will look like. We know exactly what is required of them, they can prepare for that, what hospital prerequisites training they might need and also what it will look like as far as practice placements will be and culminating in their fellowship exams.

At this stage, we're not sure what that training program will look like. We have been tasked to recruit applicants into the program for 2023 in 2022. It's very difficult.

CHAIR - If you're accredited to currently deliver their program, and the college ticks off on the program, otherwise they wouldn't accredit you, I can't imagine that would change an awful lot if they've already accredited that training program. I don't understand the change here.

Ms DEW - I think I'm on the right track now, Ruth. What it means is under the new model, the college will have to directly provide the training to GP registrars. They have to orchestrate, organise that and deliver the training directly from that college rather than using a training organisation as that provider.

CHAIR - Can't they subcontract that out to a training organisation still?

Ms DEW - No, that is not the model that is being proposed by the Commonwealth.

CHAIR - The next question is if the college are doing, effectively, what you're doing that they're accredited to do - correct me if I'm wrong - how would the change then affect GP availability into the future? Does the college have a branch in Tasmania?

Ms DEW - Yes, there is a faculty here.

CHAIR - They have a faculty here. You would expect they would have networks and knowledge about the local situation in Tasmania. It's not like someone from Canberra having no idea how long it takes to get from Strahan to Queenstown, for example. You would think they would have that knowledge.

I'm not sure why there's a need for a delay if they have already accredited programs. If the committee were to make such a recommendation we need to have it based on fairly firm evidence.

Ms DEW - The college hasn't delivered training for almost 20 years. All of a sudden, they have to set-up, gear up and create their own training program, recruit the staff and everything that goes with that so they can deliver on the ground. At the moment, our faculty office is really from a membership perspective and they're not staffed up to do that.

This is a whole new venture for RACGP and the Australian College of Rural and Remote Medicine, who is the other college, to take on at this stage. It's new territory and it's going to take an awful lot of planning and transfer of information for them to be up and ready to provide on the ground in 2023.

Ms LOVELL - Judy, you might not be able to answer this but do you know what the college's position on that is? Do they want to delay? Do they think they need more time to prepare to deliver the training?

Ms DEW - At this stage, they are committed to the February 2023 cut over date. That's part of some of their contract funding that will come through from the Commonwealth. The grant opportunity will be released this month for them to understand what funding they will

have to provide GP training across the nation. They're working towards it because, I guess, we're all on this path and the minister has decided that is the date.

Dr SEIDEL - Thanks, Judy, good to see you again. We heard earlier from the AMA that fewer medical graduates are now choosing a career in general practice than ever before.

Ms DEW - Correct.

Dr SEIDEL - Looking at your submissions, you said you can take up to 40 GP trainees in every year. You had 34 this year. Has this been rather static or do you see the numbers declining? Is it difficult to recruit more trainees into the program? Are the numbers adding up? Would you expect you could attract more if we had more funding or more resources? How do we get more GPs training in Tasmania, knowing that 25 per cent are leaving the state once they're fellowed, which I think is a huge risk? What do we need to do better to train GPs here, to get more GPs here and to make sure they stay here?

Ms DEW - I think it's all about that sort of pipeline into general practice. It starts quite early. There has been a lot of work done by the rural clinical schools also promoting general practice and rural practice. It seems to travel quite well, I think, until doctors are often into the main hospitals doing their internship and residency. Then, all of a sudden, there's a plethora of other specialties to consider. This seems to be an observation from a national perspective as well; we seem to lose that GP connection in the hospital space. There are always those who have been committed to general practice right from the get go and they're the absolute stars.

Our Tasmanian experience is that we are funded for 38 training places by the Commonwealth every year and we are finding that in this and the previous year we've received more applications than the places we have for general practice, for the main college.

Dr SEIDEL - How many applications do we get for Tasmania for the RACGP and ACRRM?

Ms DEW - For the RACGP, we're probably looking at around 40-odd for 32 or 30 places.

Dr SEIDEL - How many applications would we get for ACRRM?

Ms DEW - We don't get so many. We might get about 10 in total per year. Suitability, they don't always get right through, so it's perhaps only three to four per year.

Dr SEIDEL - So, you're saying we get around 50 applications in total but you could, in a best-case scenario, only get funding for 38.

Ms DEW - That's right. We're block funded at the moment and it's the way it works.

Dr SEIDEL - That's never changed? The 38 has been static? Although we know that fewer and fewer GPs want to come and we need more, the AMA said we are short of 100 GPs, we get static funding, so it's not a dynamic process. Do you know where the data comes from? Who decided it has to be 38?

Ms DEW - All I know is that's what we are advised by the Commonwealth Department of Health. Each RTO has their standard amount.

Dr SEIDEL - Do you have input? Can you advise the Commonwealth that, potentially, we could attract more GP trainees if you received more funding?

Ms DEW - We haven't so much advised of the funding situation but, it's only this year, if we end up with more suitable applicants than college places, we can perhaps take on more. In this scenario, we may be looking to take on more RACPG applicants because we will have vacancies because, unfortunately, our ACRRM places aren't completely filled.

Dr SEIDEL - Why do you think ACRRM isn't filling?

Ms DEW - I think that's the rural generalist question. Rural generalism in Tasmania isn't, perhaps, the same as it is in far north Queensland. Quite often that advanced skill like anaesthetics or a bit of surgical procedural is highly utilised in far north Queensland. They have a different system where rural generalists are attached to a hospital and go out into community practice. In Tasmania, a GP is out in community practice and will VMO into a hospital. Our hospital system is also different as well.

Unfortunately, ACRRM applicants are seeing not a lot of opportunity with the anaesthetics, obstetrics side of advanced skills. However, mental health, palliative care, drug and alcohol, fantastic; they're the applicants we would really like to attract. We do have several of those in our program now.

Dr SEIDEL - Specifically, then, you are saying that currently there is training in the drug and alcohol service in the Tasmanian health system for generalists.

Ms DEW - Yes, we have had an ACRRM registrar undertake that course, and mental health -

Dr SEIDEL - Okay, and the shortfall is in anaesthetics. Is there any training opportunity?

Ms DEW - There is, and I think it was recently in the news. There's a new diploma for anaesthetics that is more geared towards rural generalism.

Dr SEIDEL - Do we have the training places here in Tasmania? Can they train here?

Ms DEW - It is very difficult.

Dr SEIDEL - Are you aware of the opportunities that we don't have in Tasmania? I would assume we do not have aesthetic training here. Are there any other sub-specialties or specialties essential for rural generalism that we don't offer?

Ms DEW - I think the obstetrics certificate is also a little tricky to negotiate. The other aspect is that once a doctor has that advanced skill and they are fellowed, I guess the possibility of them being able to utilise that in the Tasmanian health system is very, very limited.

Dr SEIDEL - So, you would have qualified doctors who cannot use the qualification here. Those doctors would leave, wouldn't they, after you have trained them. It has cost the taxpayers a significant amount of money and those people are going and not coming back?

So, what communications have you had with the Tasmanian Health minister regarding actually creating those training opportunities in the hospital system, known that nationally there is a big push towards rural generalism. There hve been a lot of discussions, frameworks set up over the years now. Our understanding is based on budget Estimates. There is a ruralism trend, a rural generalist pathway and the opportunities.

CHAIR - That has been focused at the Mersey Hospital as I understand it.

Dr SEIDEL - But we are also hearing from other stakeholders as well. Actually, we do not have the training placements. All looks well on paper but actually nothing much happens on the ground.

Ms DEW - No. GPTT has a place in the Rural Coordination Unit Collaborative along with other stakeholders. That is currently a work in progress to define what rural generalism is in Tasmania and being able to market it.

Dr SEIDEL - I would have defined rural generalism nationally years ago.

Ms DEW - There seems to be a lot of confusion. You ask three people and you will get a different definition from each, unfortunately. A lot of work is going towards that. There is also the Rural Junior Doctor Training Innovation Fund. That now has more rural places available.

At the moment it seems to be a lot of moving parts but they are not quite gelling, which is unfortunate. I think there is more work underway with that unit. So, we will keep an eye on that and keep working with them.

Dr SEIDEL - It is only fair to say it has not gelled for years.

The AMA again say it will be 100 GPs short right now. How many trainees do we need every year? How many GP trainees should we have had every year in order to meet the need in Tasmanian? What is the number? What are your projections? What data do you have?

Ms DEW - We only know that about 74 to75 per cent of those whom we train complete the program and stay. That is probably the only retention data we have. If we trained more, you would think that 75 per cent number would of course be larger. You can only think about a mass perspective.

Dr SEIDEL - How many do we need to train?

Ms DEW - I would say around about 40 to 45, if they stayed, Bastian, that is the other side of the coin.

Dr SEIDEL - We would need to train 45 every year and they would all have to stay in Tasmanian in order meet future demands.

Ms DEW - Back of the envelope. I think the other aspect too is that we have an ageing GP workforce.

Dr SEIDEL - Is there any workforce modelling that GPTT does, or together with the other RTOs, in order to identify current and future need really is?

Ms DEW - No. We tend to rely on the other agencies, like HR Plus or Primary Health Tasmania, to assist with those. We have only recently been given access to the heads-up tool, which is the Commonwealth Department of Health.

CHAIR - Talking about the rural generalist approach up in Queensland. We are the opposite to Queensland. Rural generalists work in the community but they have VMO rights in the hospital. We base our rural generalists in the hospital. Admittedly, the Mersey Hospital is a community hospital. It is not providing the full suite of acute services.

Do you see benefits or disbenefits in that approach?

Ms DEW - I think it is a fantastic initiative. The community hospital at Mersey has perhaps battled a bit with an identity problem. If we really wanted to bolster that and make that a centre of excellence for rural generalist services, that would be the right way to go. But I think it has a long way to go to actually become established and probably something that people will understand and rely on. Some of the early meetings with the Rural Health Coordination Unit Collaborative suggests that some of the services that have left the Mersey years ago are still missed in that community, for example obstetric services, while they are down the road at Burnie, or something like that.

It could certainly set up and provide an absolutely fantastic solution for some of those services that perhaps the other specialities don't wish to, or cannot, be provided in Burnie or in the north. It certainly sounds like something that is very much well worth pursuing but it has to be defined really clearly about what services are provided at that site. Then I think you will find those wanting to pursue a career in rural generalism will come but at the moment it still very much appears, just from my perspective, that it is very much in a planning stage.

I am not quite sure what the actual vision is yet and so putting some more meat on the bones will be hugely helpful in trying to attract those who are considering that pathway to come forward and say, 'Yes, that's somewhere I want to train and work'.

CHAIR - Would ACRRM be the ones who would be responsible for the training of those?

Ms DEW - No. RACGP also has an advanced rural certificate as well for addition to the fellowship so that's -

Dr SEIDEL - It's quite extraordinary, isn't it? You have general practices that are accredited throughout Tasmania, including on the islands. You have one RTO. You get more applicants than you can actually employ because of funding issues. You have a hospital system that is looking for an identity, and you can't place GPs or rural generalists who really have a need of a sub-speciality as well because the places actually aren't there. Subsequently those people are actually leaving interstate for other opportunities. It doesn't make any sense, does it?

CHAIR - Especially if they can't use their skills.

Dr SEIDEL - We could train them all here. You already get the number of applications in. It would require a little bit more funding. As you said, it is not much, right - you just want to have funding for 45. You only have 38 to get to 50, 55 applicants. We could train them all here and it just doesn't gel, right, as you said.

It's a missed opportunity for Tasmania to be the centre for rural generalism training, general practice training nationally, if not the world, because we have it all here - all the suite of generalities here in Tasmania. We just don't grasp it.

CHAIR - Getting back to the point of your submission, how would the change that's being proposed and - I am not sure, maybe a senate inquiry into it has more power to influence the federal government - but how will it benefit or disbenefit meeting the need of the current demand and the future? This is really what we're trying to look at, barriers and other obstacles to getting the health needs of Tasmanians met, ideally outside of an acute setting.

Ms DEW - I think it's the risk of quite a substantial change to the current training model that is the riskier. We've got a very stable, well-known GP training system in place at the moment. It's very interconnected with the practices on the ground and all of a sudden that's going to be taken right away and it's going to be replaced with something that is very different. The GP colleges will handle the training or predominantly the education piece and that will be their focus. There will be a workforce which is all about the placement advice and that will be handled by a different organisation again.

CHAIR - Manage the fragmentation you've talked about?

Ms DEW - This is the fragmentation. At the moment a regional training organisation also provides support payments for GPs who are teaching registrars in practice. When we take those GP registrars out of that practice for training and education workshops and things like that, we also pay a bit of support for that. That's going to be -

CHAIR - To the practice?

Ms DEW - Yes, to the practice who is accredited to train. That will actually move probably across to Services Australia so it's taking everything that a regional training organisation such as ours does now and saying, 'This piece will go there; this piece will go here' and so forth and all of a sudden you have coordination inefficiency on the horizon as well.

CHAIR - You seem to be suggesting that the colleges wouldn't coordinate that or they would only do the training; they wouldn't do the placement. I would have thought that would be in their interests to ensure that the training and the placements go together.

Ms DEW - You are right. We don't have all the details of how this will happen yet either so this is part of the problem. We're heading down the highway towards this new model of 2023, when it will start and it will cut over from the current and we still don't know exactly what it looks like. The practices which are going to accepting registrars to train them, how will they be supported? There are all these questions hence people tend to hold back and think, 'I'll just wait to see how this pans out before I jump in'.

CHAIR - Like most changes.

Ms DEW - Yes.

Ms CUMMINGS - One of the most significant things we're concerned about is the perception at the moment of general practice training because of these changes. Because it's so unclear a lot of the prospective doctors who are thinking about coming in to general practice are holding off or staying in the hospitals longer so we may not see the immediate impact of it in the next year but maybe in three-or-four years' time.

With regard to working with the department's decision to go back to the college, this process is taking a lot longer than was first anticipated and now we're only 16 months away from a complete change. A lot of the key people who are responsible for delivering general practice training in Tasmania still don't know a lot of what their job or careers will look like and business models as well with practices. There is a lack of detail. That's why we are requesting, not so much a stop to it but more a pause of time to get this organised properly. This is so we don't have increased problems of doctors going into communities that we might have to deal with issues in about four to five years' time as a result of this not being handled well and delivered in consultation with key people.

One key thing about General Practice Training Tasmania is we have a very close working relationship with the Rural Workforce Agency. We stay in our area but we share a lot of information about the needs of local towns and doctors, and we understand practice needs really well because of the relationships that we have developed over many years.

The college has an intent to deliver a program that's very similar to what has been working well but currently they don't have those existing relationships with practices that are delivering on the ground training.

CHAIR - Maybe they will employ people like you to do it?

Ms CUMMINGS - Yes. They are wanting to retain a lot of the RTO staff and the wonderful supervisors and people that we have but there are no details surrounding that. There hasn't been for some time. We're finding an increase of anxiety that's occurring in valued people who are delivering this program. Either they are going to stay for a period of time or they will leave general practice training and find another area so there are those concerns as well.

CHAIR - How many people work for GPTT in terms of trainers and administration staff and things like that who do this work?

Ms DEW - We have about 15 full-time/part-time employees who are in the program support and administration and we have about 35 medical educators who are GPs in their own right who are in clinical practice and come in and help, as required, to provide medical education. They are considered casual.

Ms CUMMINGS - There is a real knowledge of their particular regions and registrars as well there. They're still asking, 'What's going on and when will we know'. It's getting to a point now where there's only a few months left. We are in consultation with the department and both colleges very regularly, and lots of those questions they don't know the answers - hence why we're here.

CHAIR - The colleges haven't given you a clear indication of how it's going to run?

Ms DEW - No. Unfortunately, until they know what their funding allocation will be, it's very difficult for them to model what they can provide.

CHAIR - I think they need to talk to Mr Frydenberg. Any other members who have questions? Are there any closing comments you'd like to make?

Ms DEW - Thank you for the opportunity, once again. It's been really great for us to come down and talk about our challenges and what's happening in our space in the next 16 months or so.

CHAIR - Thank you.

THE WITNESSES WITHDREW.

The committee suspended at 10.31 a.m.

The committee resumed at 10.40 a.m.

Ms KATIE PENNINGTON, CRANAplus, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Katie. This is a public hearing. It is being recorded and the *Hansard* will be transcribed and put onto our website at a later time. It is also streaming. You are protected by parliamentary privilege while you are in front of the committee for anything you say but this does not necessarily apply when you leave. Anything you say will be part of the public record but if there is anything you want to speak about that is confidential in nature you can ask the committee to consider that and we would make it a closed hearing at that time.

Would you like to introduce yourself? We have your submission and we have read that but if you'd like to speak more to that particularly or raise any further comments since it was probably provided a few months ago now - it was in March - please feel free to elaborate. Then the committee will have questions.

Ms PENNINGTON - I am appearing as a registered nurse who lives on the east coast of Tasmania where I also work in the state sector and the not-for-profit sector. I'm a member of CRANAplus whose submission you have, no doubt, read. I've spent the majority of my nursing career working in rural and remote Australia - Tasmania, Western Australia, South Australia and a brief time in the Northern Territory.

I hold post-graduate qualifications that are specifically relevant to rural and remote health practice, a graduate certificate in child and family health nursing, a graduate diploma in remote health practice and I'm in the final stages of completing a master's of public health.

I sincerely thank the committee members for their curiosity about the issue of rural health in Tasmania. I think the value that I can contribute to your inquiry is my diverse experience in Tasmania and the contrast in this to the situation interstate, particularly relating to models of nursing care. I feel there is an under-utilisation of the nursing workforce in Tasmania that contributes to workforce stress across all professions. It leads to access and equity of access issues for the people in our communities.

CHAIR - If you had a magic wand, what would you do?

Ms PENNINGTON - If I had a magic wand the two keys things I would do is to develop a clearly-delineated rural and remote nursing pathway in Tasmania that is applicable across all sectors and supported through regulatory measures and, if required, credentially. Similar models exist in other states of Australia and have for over two decades. We're well behind the eight-ball there.

The other thing that I would do is launch, or perhaps explore further, the funding models that are existing in the small remote communities that provide services subcontracted by the THS. So where you have not-for-profit providers who are subcontracted to provide inpatient and acute care services, the funding model behind that and the impact it has for those organisations and communities.

CHAIR - Can you give us some examples of that regarding your last point? I'll come back to the rural and remote nursing pathways, which other jurisdictions have and how they look. If you could talk about some of the examples relating to your second comment.

Ms PENNINGTON - Recently I've been working with May Shaw, a multipurpose site on the east coast of Tasmania. There's high tourist throughput. May Shaw operates some subcontracted beds for the THS, inpatient beds as well as a residential aged care facility. It is co-located with the Swansea General Practice with two fantastic GPs who provide urgent care services.

My understanding of the contractual arrangements is that they've evolved in a little bit of an ad hoc way over the last 15 or so years, with three different parties involved and none of the parties having a clear understanding of the relationship between them all.

When you compare the amount the services are funded to the National Efficient Cost for such services, it's significantly less, about half-a-million dollars a year deficit. So, you have a not-for-profit provider providing services on behalf of the state but at cost to that service and the community. The big implication of that is that it places the clinicians working in those environments under considerable strain due to lack of staffing because of a lack of resourcing. It also places the organisations at financial risk.

CHAIR - All of them, or only the NGOs?

Ms PENNINGTON - Yes, the not-for-profit organisations delivering the services.

Dr SEIDEL - There's been some acknowledgement because the Government announced the safe working program for nurses for rural district hospitals, it was around $18 million as I understand it.

Ms PENNINGTON - The sub-contracted sites weren't included in that model or rollout.

Dr SEIDEL - We specifically asked in Estimates whether sub-contracted sites would be included and the answer was they would be included.

Ms PENNINGTON - I was the clinical nurse manager at May Shaw until very recently and we were not included in that rollout. We requested to be included and we were told that the rollout was only for the state-operated sites.

Dr SEIDEL - There aren't many of them left, are there? For example, in the Huon it is sub-contracted, you mentioned May Shaw, places like Nubeena are Commonwealth-funded multipurpose centres, the funding comes through the state but it's not funded by the state. There aren't that many sites left.

Ms PENNINGTON - There's not, but the importance of those services to those small communities is really significant. If you take away all those urgent care centres, all it does is increase the strain that's already on the Royal Hobart Hospital or the Launceston General Hospital. It dislocates rural residents, many of whom are very elderly and don't have easy access to transport from their communities and all their support mechanisms.

What we see with throughput, coming back from the Royal Hobart Hospital to our inpatient facility at May Shaw, are early discharges that have been poorly coordinated, which result in people having longer hospitalisations with us because they've had to get them out of the Royal faster. Whereas, if you can better resource these sites with only what is a small amount of money, you can have smoother pathways to care. You can further reduce the burden on the emergency departments and keep your rural workforce.

Dr SEIDEL - If you are half-a-million dollars short per year, how does the organisation function? Something has to give, I would imagine, either staff pay or staff numbers. How stretched is the service on the east coast or in Swansea, in particular?

Ms PENNINGTON - It's very stressed and the people who are suffering are often the aged care residents. Nurses are stretched across the whole facility, and when you have an urgent care presentation or an inpatient whose needs are quite high, it's the aged care residents who are then missing out on the nursing care.

CHAIR - The nurses work across the whole site?

Ms PENNINGTON - Across the whole site.

CHAIR - On the rural and remote nursing pathway, which other states have models we could look to?

Ms PENNINGTON - Queensland and Victoria both use the well-established rural and isolated practice nurse model, also known as RIPERN. RIPERN model is also supported and endorsed through Ahpra, so you can apply for a RIPERN endorsement, which is then recognised by organisations through their policies and procedures and through state-based medicines and poisons legislation. This enables nurses to work with that advanced scope of practice where they're appropriately prepared.

New South Wales has a different model, it's called nurse designated emergency care and it's really only applicable in the urgent and emergency care environment. That's not endorsed at a national level through Ahpra but is regulated and credentialled through state-based mechanisms.

Both of the models evolved out of research that pointed to nursing stress, medical stress and patient dissatisfaction with time to access service in rural and remote areas and have led to improvements in that.

Having worked in other states with an advanced scope, when I moved back to Tasmania in 2018 I became deskilled. My scope of practice has been reduced and yet I can see the need that if I were able to maintain those skills and that scope, I could directly and more significantly contribute to the need for healthcare services on the east coast of Tasmania.

Dr SEIDEL - You also mentioned in your submission that there are now fewer rural isolated nursing positions and that there's been a loss of those positions in Tasmania over the years.

Ms PENNINGTON - I can't speak to that. It is obviously informed by evidence from other CRANAplus members but I first started working in rural Tasmania back in 2007 and

have come to the state off and on over the ten years between 2007 and 2018. My gut feeling is that in the primary healthcare sector there has been an attrition of nursing roles and also scopes of practice and some reduction in scopes of practice in the more acute sector roles.

Dr SEIDEL - Maternity care is also an issue. I was in St Helens just the other day where the doctor said, 'We just had a twin delivery'. I said, 'That's great. How did you work with the midwife?' There was nobody trained in midwifery at all. St Helens is a nice hospital, a nice facility now, but still the skills are not there to meet the need. That's a concern, isn't it? You would expect when patients are moving to St Helens they expect nice care. And babies will appear, right?

CHAIR - Sometimes babies arrive in a hurry; we know that.

Dr SEIDEL - A twin delivery.

CHAIR - That's right.

Dr SEIDEL - Do you think it's a concern that we have a lack of maternity care or nurses who are also trained as midwives in regional Tasmania in particular?

Ms PENNINGTON - Absolutely. Nationally there was a big shift of maternity care away from small regional centres in the 1980s and again in the 1990s.

Sometimes there are safety issues for that in that birth numbers aren't high enough to support the ongoing skillset. However, when you look at the east coast of Tasmania with its increasing birth rate, the biggest concern for myself, as a nurse, and for community members and my friends who are all women of child-bearing age, is the lack of local antenatal and postnatal care.

Access to healthcare services is quite costly for people who live in rural areas. You lose a whole day of work to travel to town to see a specialist. If there's any reason you can't have multiple appointments lined up on the same day, then you stay overnight. A lot of people aren't aware of the Patient Travel Assistance Scheme (PTAS) so bear the financial cost of the travel and also the loss of time at work.

Women don't have ready access to antenatal or postnatal care which you do in other areas of the country. In rural areas you do have antenatal and postnatal care midwives who are either located within communities or regularly and frequently travel to those communities to provide a service. That is something we're certainly lacking.

CHAIR - If you have midwives providing antenatal and postnatal care based somewhere on the east coast, probably more one centre because the east coast is quite a long distance, how do you see overcoming the diminishing of their scope of practice if you're not involved in labour and birth care?

We are seeing this on the north-west at the moment. I am interested in the model that you see. Is there one in another rural setting that provides midwives with that full scope? They're still delivering essential care and when the unexpected twin birth happens you've got midwives around who can assist and are competent in labour and birth care.

Ms PENNINGTON - I'm not a midwife, so I'm not the best person to speak to that. However, I do have friends interstate who practise in the remote environment who are midwives. Their employers support them to take unpaid leave from their regular work so that they can be based at regional birthing centres for four to eight weeks per year to maintain birthing skills. Whilst I couldn't say what the solution is, I'm sure that there are solutions in mainland Australia that the state could look at without reinventing the wheel.

Dr SEIDEL - I'll follow up on this. That's the development in medicine where if you want to train in rural generalism as a rural generalist GP or even rural generalist surgeon, the caseload might not be there, so you just will take it out as part of your training or ongoing work to spend some time in a major centre to do your abdominal surgeries or endoscopies or deliveries. It's just part of what they do. There's no need for unpaid leave; they're getting paid for that. It's what they do, that's the job. Those models seem to exist in medicine and are encouraged and financially supported by states and by Commonwealth governments. You are saying not so much in Tasmania for nurses?

Ms PENNINGTON - Nationally for nurses there is a lack of financially supported and accepted rural development and progression pathways for nurses. When nurses undertake additional training to become a RIPERN or other aspects of nursing, it is usually done at their own expense, taking leave from work or juggling part-time work or part-time study so that they can meet those needs.

CHAIR - Unacceptable.

In terms of Tasmania maintaining the full scope of a nurse's practice, can you talk through a bit more about how that is or isn't working in our rural settings? You've talked about the shortage of staff in our smaller rural hospitals but is there a model - we talked a little about this - that nurses have to go off and find their own upskilling to maintain those competencies? If you're going to sign off on your Ahpra registration and you sign off that you're competent, that means you're competent at a base level across all those skills that you're expected to have. How is that working in our rural setting and what needs to happen if it's not?

Ms PENNINGTON - My experience within the state sector is that there are some clear and supported pathways for advanced nursing scopes of practice but they tend to be more based in the larger centres. For example, working in an emergency department in Hobart or Launceston as a registered nurse who is not a nurse practitioner, I could undertake some training and be credentialled to suture for certain types of wounds. This is a skill that I have used for many years interstate and I returned to practise on the east coast of Tasmania. Because that credentialling does not exist within that section of the THS north, I can't use that skill, which then means I'm placing undue burden on the doctors who provide the rural medical practitioner service. I might be calling them in after hours, which places a burden on the patients who are having to wait longer to have wounds sutured when I have the skill that I have been credentialled to use and apply elsewhere in the country.

It' s mindboggling to me that we can have pathways for that in our big hospitals where you have a lot more doctors and you have interns but in environments where nurses are there all the time and are the backbone of the service, that same pathway doesn't exist.

Dr SEIDEL - And often the nurses will be the only health practitioner present.

Ms PENNINGTON - Absolutely.

Dr SEIDEL - Cape Barren Island, for example.

Ms PENNINGTON - Absolutely.

Dr SEIDEL - Or Bruny Island on weekends or on Tuesdays and Thursdays.

Ms PENNINGTON - Yes.

Dr SEIDEL - If there is a suture required, the patient would then need to be transported off the island to receive sutures. And if it was within the scope of practice of remote area nurse, wouldn't it be great for the patient and the health system because of the significant cost savings there?

Ms PENNINGTON - That is right. It doesn't and it places pressure on nurses who have those skills and know that if they did apply them, because it is within their individual scope, but it is not within the organisation's scope. So, that creates moral distress for nurses.

Dr SEIDEL - The organisation doesn't meet the needs of the patient? I would imagine the patient needs to go, the practitioner is ready, it is the system.

Ms PENNINGTON - It can be local policies and protocols that do not support that. That can be a limiting factor. In some instances, it is the only limiting factor.

Dr SEIDEL - Again, that would be a no-cost option for that to change, right?

CHAIR - If you provide the credentialling.

Dr SEIDEL - That is right. You were credentialled interstate. You are obviously competent. You have demonstrated competence. But it is the system that does not allow you to work to the full scope of your practice because you have found yourself on the east coast in Tasmania.

Ms PENNINGTON - The same for nurse-initiated X-rays. Nurses in Burnie, there is a pathway in the emergency department where they can be credentialled to nurse initiate X-rays in appropriate circumstances. That same pathway does not exist on the east coast and is a big frustration for the radiographers, medical practitioners and the nurses.

CHAIR - Do you know how the nurses receive that? Is it an accreditation or credentialling to do it?

Ms PENNINGTON - It is an internal training package and then a period of supervised practice which is recognised by the organisation that they are employed in. Which is the THS, one individual health service. So, I do not see why nurse credentialling pathways that exist in one service cannot be applied across the state.

CHAIR - So, there is no consistency with this?

Ms PENNINGTON - No.

Dr SEIDEL - You also mentioned initiation of analgesia in those circumstances. Is it any particular analgesia or literally any analgesia including some paracetamol or ibuprofen?

Ms PENNINGTON - Nurses in the THS can nurse initiate some analgesia. However, when you think about narcotic analgesia, if you have a fracture that comes in the door, somebody who has fallen off a mountain bike at St Helens or Derby. If that same fracture walked in the door at the Royal Hobart Hospital, they could be triaged by a nurse who has undertaken nurse initiation of narcotic analgesia training and be credentialled to do that. And, the nurse can initiate that analgesia according to a protocol and within limitations -

CHAIR - It is a standing order?

Ms PENNINGTON - Yes. That does not necessarily exist at all our rural sites.

Ms LOVELL - Why not?

Ms PENNINGTON - Good question.

CHAIR - Are you aware of what the particular barriers are to that?

Ms PENNINGTON - I am not aware of what the barriers are to that. I have not held any management positions within the THS. I practise as a registered nurse on the floor, so I cannot speak to what the barriers are to that. But I do not see them as insurmountable. If something can happen at one facility and one region of the state, why can't we transfer that?

CHAIR - For the benefit of the committee, would you mind talking about the difference between a registered nurse whose credentialled in a particular area like suturing, as opposed to a nurse practitioner?

Ms PENNINGTON - Nurse practitioners have their registration endorsed by Ahpra. There is a process behind that. It usually involves undertaking a master's degree, and nurse practitioners specialise in a particular area of practice. I am not a nurse practitioner, so I cannot speak for them in Tasmania. I am aware that we do have some fantastic nurse practitioners here, but they seem to be more, once again, in larger centres and in specialty areas.

In some areas of Australia there are nurse practitioners in rural and remote practice, who significantly reduce the strain on the whole health system within their individual and appropriate scopes of practice. Just like doctors who practise within their individual scope of practice, nurses have that same responsibility, as do allied health professionals.

CHAIR - Okay, and what is the difference between that and a credentialled nurse?

Ms PENNINGTON - Currently in Australia, credentialling is organisation-based. I can be credentialled by one organisation to undertake some certain skills and that may not be transferred or recognised in another organisation. It often ties into broader mechanisms of clinical governance, what those organisations understand and how they want their clinical governance mechanisms to operate. When it comes to nursing practice, that can often be dependent on the understanding of the clinical governance committees and management of the potential for nursing practice. If people haven't worked in environments, worked with nurses

who have advanced scope of practice or seen the impact it can have on health care, they're not going to realise that potential and they won't build it into those mechanisms.

CHAIR - As you understand it, if the THS was to provide credentialling for, say, suturing for nurse-initiated X-rays or other sorts of investigation, whatever it is, that should then apply across all nurses who have done the credentialling course or program in the THS? I don't understand why that's not the case.

Ms PENNINGTON - Neither do I.

Dr SEIDEL - It's discrimination of rural communities and rural practitioners, isn't it? Let's face it.

Ms PENNINGTON - It is.

CHAIR - They're not given the same opportunities.

Dr SEIDEL - It's discrimination, that's what it is.

CHAIR - Yes. Any other questions?

Dr SEIDEL - Yes, I have a question with regard to nurse practitioners. Are you aware of any funding support to become a nurse practitioner and to obtain a master's degree? Is there any funding the state government offers?

Ms PENNINGTON - I am not sure about the state government. There are a number of scholarships you can apply for to support the cost of your training. I think one of the biggest challenges with getting more practitioners in the workforce is that, to become a nurse practitioner, you have to have 5000 hours of advanced practice. It can be very difficult to be in a position where you haven't accepted advanced practice because of the limitations of organisations. It is a significant period of study and, in addition to that, you need to have 300 hours of supervised clinical practice.

If you look at the cost of that for a nurse, 300 hours of unpaid clinical practice on top of time off work to complete the master's study, I can certainly understand why there aren't more nurse practitioners in this state. Although, off the top of my head I can think of at least 10 clinicians who, if there was a financially-supported pathway, would probably put their hand up and take it on.

Dr SEIDEL - So, there might be scholarship for the master's degree, for James Cook University (JCU) for a year or so, but, again, because you have to do on-site training as well, basically, you work for free, isn't it? That's what it would be.

Ms PENNINGTON - Yes.

Dr SEIDEL - It's no surprise that it's not being taken up.

Ms PENNINGTON - That's right.

CHAIR - Is there anything you wanted to add before we wrap-up?

Ms PENNINGTON - I think it would be a relatively simple thing for Tasmania to implement a statewide recognised education and training pathway for rural nursing practice that can apply across both the state and the not-for-profit sector. It would have a significant positive impact both on the communities, but also the profession and the satisfaction of the workforce and reduce the burden on the workforce more broadly.

CHAIR - You did talk about the challenges associated with working at May Shaw, because of the differing arrangements there. When you see a pathway that's developed for the Tasmanian Health Service, perhaps, which oversees the majority of our rural hospitals and all our acute hospitals, is it their role to look at that? Whose role do you see this as being to develop such a pathway as part of a program to see a more coordinated approach and one that's going to have some benefit when people come out of the other end of it?

Ms PENNINGTON - I can't speak to whose responsibility it is. That's probably a question for the Department of Health. However, in other states it's been jointly done between health departments and universities or other education providers. It's then up to the individual organisations to recognise that credentialling and enact it within their clinical governance arrangements.

One of the challenges that may exist for Tasmania is making changes to the medicines and poisons regulations. My research that's associated with my master's has examined the impact of medicines and poisons regulations on nursing practice in the remote environment, nationally. Tasmania has a number of challenges there. None of them are insurmountable. It takes drive and desire.

CHAIR - I guess it's a bit of a chicken and egg situation. There's probably no point amending the Poisons Act if we have no one who needs to change it for, or are there limitations within the Poisons Act now that are limiting the scope?

Ms PENNINGTON - Absolutely there are limitations. Not having been to Cape Barren Island but having worked in remote communities elsewhere, I always wonder how they get around the limitations in the Tasmanian Poisons Regulation around nurses supplying medicines.

CHAIR - If there was a credentialled or a recognised pathway that was maybe a collaboration between UTAS and the THS, then there would be a real need to revisit that and make sure the Poisons Act wasn't a barrier.

Ms PENNINGTON - Absolutely.

CHAIR - Currently, do you see that's a barrier? Because we don't have that credentialling process, it makes it a problem.

Ms PENNINGTON - It's a challenge. It's not a barrier because of some of the limitation on nursing scopes of practice but it can be a challenge.

For example, if you think about rural and remote emergency departments where you have a nurse after-hours and a child might come in with raging acute otitis media in the middle of

the night. You're trying to get them home back to bed as soon as you can but you have to wait for a verbal order for the supply of the appropriate antibiotic because of our current regulations.

We have the fantastic GP Assist phone line that provides that support after-hours but they're under the pump. I've been in situations where after hours I've been waiting three hours for a verbal phone order before I can send somebody home.

Dr SEIDEL - Is there not a priority line for health professionals?

Ms PENNINGTON - That's through the priority line.

Dr SEIDEL - And that's happened on more than one occasion?

Ms PENNINGTON - On more than one occasion there's been a delay of more than an hour.

Dr SEIDEL - Was there somebody to take the call or your call had already been triaged?

Ms PENNINGTON - My call has been triaged and I'm waiting for the call back from a doctor.

CHAIR - I'm wondering if there are any peak times and if that's the case or is it random? It doesn't matter when.

Ms PENNINGTON - It can be random. Sometimes you can get a call back within 15 minutes; other times you can be waiting a really long time. Sometimes you even have to do a follow-up call and say, 'Hey, I rang two hours ago. When am I getting a call back?' These are all general practitioners -

CHAIR - These are the health professionals, not the members of the public.

Ms PENNINGTON - Yes, this is the priority line.

CHAIR - Going back to the credentialling process, if there was to be a collaboration between the THS and UTAS, we do now have full nursing degrees at the Cradle Coast campus in Burnie. They have a beautiful new lab there. You should visit it if you haven't seen it. We have a great lab in Launceston as well.

They're set up and there's been significant investment. A lot of taxpayers' money has gone in to develop those. You'd think it shouldn't be too hard.

Ms PENNINGTON - I don't think it should be too hard. There's already a graduate certificate and graduate diplomas elsewhere in the country. It's just that the pathways for their recognition and to support that advanced practice don't exist in Tasmania. We don't have to reinvent any wheels; we have to support the nurses who already have that practice and implement it and then grow the next generation.

CHAIR - Do you think there's been more of a focus on getting nurses to become nurse practitioners rather than taking this broader approach?

Ms PENNINGTON - I can't really answer that question.

CHAIR - I can see benefits and disbenefits of that.

I was keen for you to describe what a nurse practitioner looks like. So, whilst they've got an expanded scope, it's still limited. It's limited to that scope under which they've done their nurse practitioner training. Whereas what I understand you to be talking about is a broader credentialling process so when you're working in rural/remote areas when you, the nurse, are the only person there or you are supporting a smaller group of practitioners and working together, a broader set of skills would be more effective than just, say, being a diabetes specialist or sexual health specialist or whatever it is.

Ms PENNINGTON - I think the difference is that credentialling can often be around the delivery of a specific skill. You might have a nurse who is credentialled to suture, a nurse who is credentialled to initiate X-rays. Working with medicines is a bit different. I think being a nurse practitioner is a fantastic role but it's a very long and difficult process for a nurse to become a nurse practitioner. There just aren't enough of them. You have to look at what can you do to fill that gap between a base level registered nurse and your nurse practitioner and when you have credentialled advanced practice models, it's like a stepping stone and it fills that gap.

CHAIR - Then you've got to deal with the turf wars.

Ms LOVELL - Katie, I just noticed in your submission that you mentioned many of your colleagues and peak bodies were unaware of the inquiry. Is there anyone in particular that you think we should be in contact with or we might not have heard from whom we could potentially follow up with?

Ms PENNINGTON - That's a good question. You might like to contact CRANAplus. CRANAplus weren't aware of the inquiry and neither were any of my colleagues on the east coast until I came across it. I heard about it on the radio. I started a process of talking to my colleagues and to CRANAplus, of which I'm a member, about the inquiry. I was really excited to hear it was happening but I guess if you haven't had submissions from the Australian College of Nurse Practitioners - You have, that's fantastic You've got your medical workforce agencies. Yes.

CHAIR - Thank you very much, Katie.

Ms PENNINGTON - That's all right, thank you.

CHAIR - We really appreciate you coming in and for your very personal experience and information you've provided because it does help paint the picture of what it's really like out there.

Ms PENNINGTON - I'll look forward to hearing the recommendations that come out at the end.

THE WITNESS WITHDREW.

The committee suspended at 11.19 a.m.

The committee recommenced at 11.22 a.m.

Ms SONYA WILLIAMS, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

CHAIR - Welcome, Sonya, to our hearing. We appreciate your submission and your willingness to come in and speak to us.

For your information, this is a public hearing. The hearing is being recorded and broadcast. The transcript of the *Hansard* will be put on to our website. If there is anything you want to talk about you believe is confidential or personal in nature you can make the request to the committee we do that in a private session and the committee would consider that, otherwise it is a public hearing.

Everything you say in front of the committee is covered by parliamentary privilege. That is not so much the case when you go out, so feel free to speak freely while you are here.

Are there any questions you have before we start?

Ms WILLIAMS - No, I do not think so.

CHAIR - I will get you to take the statutory declaration. It is sworn evidence you are giving and then invite you to introduce yourself, say anything you want to add to your submission and members will have questions from there.

Ms WILLIAMS - My name is Sonya Williams. I have lived in the Brighton municipality, specifically Gagebrook, for 39 years. I was on the Brighton Council for 15 years and have worked in various community groups and am still working in community groups. I also work in a Brighton initiative which is the Brighton Care Collective which looks at health issues in the Brighton area.

Have you got a copy of my submission?

CHAIR - Yes, we all have it.

Ms WILLIAMS - We have three doctors surgeries in Brighton. This morning I rang around and one doctors surgery now does not even have a doctor; they had a locum who had to move on. Today, we would have six doctors looking after about 18 000 people and it is hard. Most of these surgeries have closed books now and are not taking anyone else. People have been known to go to Kingston, Campania, wherever they can to get a doctor.

Ms LOVELL - Sonya, is that three surgeries in the entire municipality?

Ms WILLIAMS - Yes, and we have Kutalayna Health which is the Aboriginal health centre.

CHAIR - In Brighton?

Ms WILLIAMS - Yes. If you go out of the area for a doctor, nobody bulk bills. Very rarely does anybody bulk bill now, so a visit can be up to $85 for consultation. I know you get

some back, but a lot of people do not have that $85. For a first visit, it can be up to $150. People in Brighton, we do not have that money. A lot of our people are battling to pay rent, keep a roof over their heads and pay for food. They will not use the doctor. We wait until things are bad, call the ambulance, then go into emergency. In fact, from 2018 to 2020 there were 13 883 admissions to ED and 7128 of those were from Brighton, a high number.

CHAIR - That is the Hobart ED.

Ms WILLIAMS - Yes, the Hobart ED. A lot of people are using the ED as their doctor surgery. There are no after hours. The nearest one would be at Derwent Park, you battle to get in there. If you do not have transport it is even worse because there are no buses that run. You are out of that -

Ms LOVELL - They are only until 10 o'clock or something, anyway, aren't they?

Ms WILLIAMS - Yes. Call the Doctor will only go to the start of Brighton township, and then they only take a certain amount of cases from the area each night.

CHAIR - What is Call the Doctor?

Ms WILLIAMS - That is a doctor you can ring and they will come to the house, but they now charge also. They used to bulk bill.

CHAIR - Where are they based?

Ms WILLIAMS - In Hobart somewhere, because they do a fair area, but they might only do six to the Brighton area a night. We do not have any after hours and that is why they are relying on the emergency department. One woman had a child who was vomiting and ended up in emergency as she could not get into a doctor anywhere. It was the only place she could get help. There is no X-ray. My idea would be an integrated medical centre, where we could have an after hours. We could have X-ray, it does not have to be the top, just the basic X-ray scan.

If your child breaks an arm at school, you have to find a GP to write a referral for the X-ray, you have to get to either Glenorchy or Rosny and hope they have a vacancy, otherwise the closest is South Hobart and back to the doctor to find out what is going on. If you do not have transport you are relying on the buses. It is all day.

We have found parents are missing appointments at the Wellington Clinic because, by the time they drop a child off at school and get a bus to get into town, hopefully their appointment's on time, then they have to get the bus back out and hopefully, they are home before the kids knock off school.

I know everywhere is suffering at the moment. At the moment, we are close to 18 000 people, with Centacare Evolve, for example, putting more housing in all the time. You're adding up. The Puplic Health Information Data Unit states life expectancy for a male in Gagebrook is 66 years, a female, 65. If you look at the same thing for Sandy Bay, their expectancy is 83 for a male and 87 for a female.

We have lots of chronic health issues. We are the highest smoking area, which leads to other issues like dental. Dental is in New Town. People will not get the bus. They cannot afford the $40 to pay for the dental. If you do not go to the dentist, then your health suffers, so everything builds up. It is bad. I know it is bad everywhere, but it affects me because I have lived there for that long and you see a lot of people really suffering, a lot of parents have health issues. They have put their kids first. They get their kids to doctors if they can but then their health suffers as they cannot get to anything.

It is not only Brighton. It is Kempton, Bagdad. If there was something in Bridgewater, at least those places would be able to access it as well. It would be more central and maybe we could take some pressure off the emergency department.

CHAIR - By your figures, you probably could. Are you right for questions?

Ms WILLIAMS - Yes.

Mr GAFFNEY - Thank you, Sonya. I taught at Bridgewater for three years in the 1980s and loved it. I lived at the back of Tea Tree Road and it was a beautiful spot.

You mentioned that you have had some experience with the council and Brighton Council is highly regarded in the LGAs. What is council's involvement in helping to attract health services to the area or their plans? Some smaller council areas actually support different health services because they realise it is hard to attract them otherwise.

Are you aware of Brighton's involvement in some of those health services?

Ms WILLIAMS - The Brighton Council funds the Brighton Care Collective, which is involved with health issues in the area, looking at what gaps there are. I know our general manager has been in talks about trying to improve the area and to try to chase up some doctors somewhere. So, he is very much involved in trying to improve this.

Mr GAFFNEY - If you had a health issue that was obvious to the community, would there be somebody on council that you could go to speak to about what they could do to assist you?

Ms WILLIAMS - They probably would come to me and then I would talk to James, our general manager, to see what next steps we could take.

Mr GAFFNEY - Are you aware if the council helps to fund any health services?

Ms WILLIAMS - Only this one that I am involved in.

Dr SEIDEL - You mentioned it is rapid growth projections, so it is meant to triple over the next 20 years. Do you think because you really do not have the health services - and you cannot pluck them off the trees - that there is actually a limit that council says that we cannot approve further development, further sub-divisions because we have no input, we don't get the medical practitioners, community nurses we need to serve the community? Or, do you think that is actually not the role of the council, that is the role of the state government to supply those health workers?

Ms WILLIAMS - I know James has been in discussions with Centacare Evolve and everything, so that they can put forward a plan to push for more health services.

Dr SEIDEL - It is councils that approve the sub-divisions and the developments and I would imagine you would think of the consequences of approving that more people are coming in.

Ms WILLIAMS - He is aware of that and he is working hard behind the scenes to try to see if we can get more doctors. The trouble is out there people with their limited income, they want bulk billing, and doctors prefer not to bulk bill. I have been told by one that they can work in Moonah for a day and earn the money they could make in a week at bulk billing, so they prefer not to go out there. But, our people just cannot afford it. They either will not travel out of the area because of social anxieties. There are people who will not leave the area at all. The bus system is bad. It could be a two hour trip into town. And then if you get the bus back and it drops you at Bridgewater, you may have to wait another hour to get one that goes to Gagebrook. So, it is a long process.

CHAIR - That system is working well, isn't it?

Ms WILLIAMS - It is amazing. We've just had people get sick because - I know the ambulance is absolutely pushed and a lot of our people, I will tell you now, will use it as their service. Whereas it means other people are suffering. We've had a lady who waited four hours for an ambulance, ended up in ICU because of the wait. And dental health, it would be lovely to see - we have the child dental health service, it would be lovely to see that open one day a week for adults, so that they could get - because they won't travel to New Town. By the time buses and schools and everything, if you want an emergency appointment you have to be there before 8.30, which if you've got to take kids to school, you just can't do.

CHAIR - Brighton's not considered a really remote community and that's perhaps the problem here. The Royal Flying Doctor service is providing a lot of these services in rural and remote communities, including dental. Has there been any communication between the Royal Flying Doctors and the council perhaps in trying to broker something here?

Ms WILLIAMS - I don’t think there has because, quite honestly, I thought they would be more out.

CHAIR - They are but clearly there's an unmet need here. You could argue it's not the responsibility of the Royal Flying Doctor Service either. It's the responsibility of the state perhaps to understand the need, and not only the need in terms of the number of people who live there and how far to the nearest health service, but also the demographic and the other challenges associated with the demographic of the individuals who live there with access to transport and things like that. I don't know if you have a view on whose role it is to fix this?

Ms WILLIAMS - To be honest, I just want help. Whatever we can get. Just to get some more doctors and doctors that will stay. One doctors surgery said, 'We have six doctors,' and I said, 'That's more than anywhere else.' She said, 'They only come in on a rotating basis though'. So, the patients don't have any consistency. Every time they're seeing a new doctor and going through everything again.

CHAIR - They rely on locums a lot, is that what you're saying, or part-time?

Ms WILLIAMS - Part-time is the idea I got from them, yes.

CHAIR - Are the GP practices privately-owned GP practices or are they run by Ochre or someone like that? Again, Ochre are usually in the regions, not in the - what would be considered - is Brighton considered metropolitan? It is, yes. So, it makes it a bit of a challenge, yes.

Ms WILLIAMS - I know Greenpoint is run by IPN.

CHAIR - All right.

Ms WILLIAMS - I'm trying to think. Is it Sonic Health, one of them? Yes.

Dr SEIDEL - It's two corporates, one large corporate and one small corporate, one private practice.

Ms WILLIAMS - Right.

CHAIR - Okay. With the corporate ones then, even the private one for that matter, you'd think that they would expand to meet the need. Obviously, if they can charge every patient that comes through the door, which they would, whether it's bulk billing or charging the full fee, do you understand why that's not happening to meet the needs of the community?

Ms WILLIAMS - I've spoken with Christy Hunt who is in charge of IPN and the Greenpoint Clinic would be the landlord. It's actually owned by someone else and they lease it from them.

CHAIR - So, there's limited space there. Yes.

Ms WILLIAMS - There's room to expand, they just don't have the money. The landlord is quite open to expansion, it's just finding money to expand.

Mr GAFFNEY - Do you know if there's an Aboriginal or Islanders set up because I know there's quite a large Indigenous population within your area? Are there any services there provided through that mechanism that you know of?

Ms WILLIAMS - Kutalayna Health is based in the Brighton Community Health Centre and that deals with Aboriginal people and their families in the area.

Mr GAFFNEY - Okay.

Ms WILLIAMS - Yes.

CHAIR - And they provide general practice?

Ms WILLIAMS - General practice, yes.

CHAIR - I know that you've said that most of the GPs have closed their books and I assume the same with the Aboriginal service.

Ms WILLIAMS - No, they're quite good still at the moment, yes.

CHAIR - You can still get in there. If there's reasonable capacity during the day. It sounds like it's more after-hours?

Ms WILLIAMS - After-hours, yes. That's the real issue and that's where they're relying on ambulance and the emergency department.

CHAIR - You also mentioned the high rates of smoking in that area and other chronic disease that obviously adds to the burden. Are there any other health-promotion programs that are run there that would help to deal with some of those things?

Ms WILLIAMS - It's trying to get the people engaged in them. We've rung cease smoking campaigns, healthy heart campaigns, everything. It's trying to get people to engage because a lot of them are like, 'Well, it's my life and I'm going to do what I want to do. You can't tell me what to do'.

CHAIR - We ran an anti-smoking program in Smithton and it's been done in Glamorgan-Spring Bay and Kentish, I think, to incentivise through financial reward smoking cessation. In Smithton, it had a success rate of around 40 per cent, which was higher than the others, and an astounding result when you consider most other programs don't have anywhere near the success.

Maybe you could try to run a pilot there.

Ms WILLIAMS - Yes, we could try.

CHAIR - It is only a total of $310. It's not a huge amount.

Ms WILLIAMS - We have had Irena run a training course for some of the service providers on the program so they can then refer people. Through the Care Collective, we've run different programs. We have a suicide prevention action plan that now comes under the Care Collective. Another issue in the area is high suicide rates.

Because of the lack of doctors, our young people can't get mental health plans done.

CHAIR - Can they access the Allied Health Services like psychologists and social workers? Are they available?

Ms WILLIAMS - We do have Relationships Australia. They found that when they had clients who asked about appointments at New Town, they weren't turning up because they won't leave the area. They now come out to Green Point a couple of days a week. Everyone's turning up.

CHAIR - That's good.

Ms WILLIAMS - It's a thing where you need doctors or school nurses referring in.

CHAIR - Do you have social workers available?

Ms WILLIAMS - Yes, we have social workers.

CHAIR - I imagine there's a need for that.

Ms WILLIAMS - Yes. We need better mental health for our young ones. We have eight- and ten-year olds using drugs out there. There needs to be something.

CHAIR - You need alcohol and drug support and that sort of thing as well.

Mr GAFFNEY - That's an alarming statistic when you talk about 65- and 66-year-olds compared to 84 and 85, 20 kilometres away. That's horrendous, isn't it?

Ms WILLIAMS - It is.

Mr GAFFNEY - Not being able to get to health services because of the lack of transport or suitable transport adds to the lack of services.

Dr SEIDEL - When you have children that age who are using recreational drugs already, how does the school manage?

Ms WILLIAMS - A lot of them don't go to school.

Dr SEIDEL - I will follow up. Do they ever want to go to school? There would be a school nurse there, hopefully. According to the Government there should be school nurses there. If they don't even manage to go to school, they're on their own, really, aren't they?

Ms WILLIAMS - Yes, they are. It's a lot of them.

CHAIR - One could argue, you need a much higher investment in an area like this, going back to the figures Mike spoke about. If you don't intervene early, it's only going to get worse.

Ms WILLIAMS - Yes.

Dr SEIDEL - The life expectancy rates are current. That's future predictions. That's not retrospective. If that's the life expectancy, that's predicted life expectancy. You already know if things stay the way they are now, this is the gap we are going to get.

CHAIR - That's not acceptable.

Dr SEIDEL - I don't think it is acceptable. I don't think you think it's acceptable either.

Ms WILLIAMS - No. It's scary. We live in a lower socioeconomic area but we should be entitled to have the same life span as anyone else. Sometimes you feel like it's people don't bother because it's, you know -

CHAIR - It becomes a self-fulling cycle if you do not have the intervention.

Ms WILLIAMS - Yes.

CHAIR - As you said, for these young children there is no other option.

Ms WILLIAMS - No, that is it. We have second and third generation welfare dependency out there. It has got to be broken. With health we are going to have higher dementia rates there because we have all the indicators for that with smoking, obesity, low education standards so dementia is going to go up. We have heart issues, everything is increasing.

Dr SEIDEL - Even if there is no future population growth, the health needs would still go up, but you are predicting a future population growth on top of that without any way of addressing the social determinants of health for starters, let alone talking about screening, early intervention.

Ms WILLIAMS - It is scary. It really is.

CHAIR - Thank you for coming and telling us about that because these are the stories that we as a community need to hear, but the parliament also needs to hear. They will hear that through this committee of work and also one the Government needs to hear in order to start addressing them. It is not like it is major news in many respects.

Ms WILLIAMS - I know everywhere at the moment.

CHAIR - We had known this is an area that is challenged. It is well time from what you are telling us that more action needs to be taken. Thank you for coming and telling us about it and identifying those gaps or perhaps, massive chasms. Certainly, we will consider your evidence in our report. Thank you.

Ms WILLIAMS - Thank you for listening to me waffle on.

CHAIR - It is very important to hear from people like you.

Mr GAFFNEY - Well done, you spoke very well.

Ms WILLIAMS - I am passionate about my area. I love my area.

Ms LOVELL - That is a good thing.

CHAIR - We need to hear from people like you, because otherwise we just hear from the big representative groups who do not understand what it is like at the ground sometimes. Thank you.

Ms WILLIAMS - Thank you.

THE WITNESS WITHDREW.

The committee suspended at 11.47 a.m.

The committee recommenced at 11.48 a.m.

Mr SHANE JOHNSON, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

CHAIR - Welcome Shane to our hearing. We appreciate you putting in a submission and raising your concerns with the committee.

This committee is a public hearing. It is being broadcast and is also being recorded and transcribed by Hansard and will be published on our website at a later stage.

If you have anything you want to discuss that is of a private or confidential nature you can make that request to the committee and the committee will consider that.

Everything you say in front of the committee is covered by parliamentary privilege, but that does not necessarily extend when you are outside the hearing.

We invite you make a statutory declaration in a moment because it is sworn evidence you are giving and then speak further to your submission and tell us a bit about yourself and what brings you here perhaps.

Do you have any questions before we start?

Mr JOHNSON - Not about the process.

CHAIR - Great, thank you. Would you like to introduce yourself? Talk about yourself and what brings you here. I know you are concerned about the ambulance service in the Huon.

Mr JOHNSON - My name is Shane Johnson and I am a Franklin resident. I made an initial submission as a private citizen, but I have been asked by the Franklin Progress Association to attend the hearing to provide further information.

As you said, my submission is about the Huon ambulance service and the provision of that service. I have prepared something, if that is okay?

CHAIR - Yes, you are quite welcome to read that.

Mr JOHNSON - The information I am giving stems from information given to me by volunteer ambulance officers over the last three years, so my interest has come from that. The issue is one that affects the entirety of the human population. It is not something confined to the south coast or the outer reaches of the valley. It is the main street of Huonville experiencing the issues we find.

I know the stories I have been hearing will be related across the regions in Tasmania, and what I say is not a criticism of ambulance officers and the care and treatment they provide. People overwhelmingly say the treatment is first class. The call-out times in the Huon are haphazard at best. When people dial 000, they just do not know what will happen, how long it will be before help arrives. This is highlighted in the following email I received:

Hi Shane,

> Brett concurs with my recollection of what happened with Murray in early 2017. Three hours would not be an exaggeration. Just to add to the picture, when my father-in-law collapsed at our place at South Franklin in about 2015, there was an ambulance with us in 15 minutes.
>
> It all depends, I imagine, on whether or not there is a vehicle and crew in Huonville at the time. When Margaret, his wife, collapsed with a severe stroke, the delay was approximately 45 minutes as somebody had to come from Kingston.

Murray died in hospital two days later and Margaret died in the ambulance en route to the Royal. His father-in-law was okay.

There are lots more cases I have heard about over the last week and will summarise briefly. A person with a compound leg fracture waited for just over three hours; despite living one minute from the Huonville station. A man experiencing severe abdominal pain - who required hospitalisation and an operation - waited for an ambulance from 2 a.m. to 7 a.m.

A lady who had previously experienced anaphylaxis had a moderate allergic reaction, contacted the ambulance and was told no ambulance was available even though she had previously had anaphylaxis, but to call again if her symptoms worsened. Fortunately, they did not.

A Lucaston woman's husband woke in the early hours of the morning in July 2020. She heard a loud crack and rushed out to the kitchen, where she found him collapsed on the floor with blood around the back of his head. The ambulance took 45 minutes to arrive and their home is 10 minutes from the ambulance station.

A woman advised me she has taken penicillin all her life, then approximately 4 years ago she took some and had an anaphylactic reaction within 20 minutes. She required an injection of adrenaline from her doctor and two further injections in the ambulance on the way to hospital. She says -[tbc]

> Timing is paramount with anaphylaxis. If the ambulance is in Kingston or Hobart, then they would not make it to me or someone else in time. However, if they were in Huonville people would have a chance.

Another person in South Franklin has said -[tbc]

> When I had my heart attack last year, there was no ambulance available in the Huon. I was pretty out of it but I think there was about a 50-minute delay until the ambos could get to our place. They called for a cardiac paramedic service, which met us halfway.

Another heart attack sufferer in Cygnet experienced a wait of three-and-a-half hours for an ambulance, and that ambulance came from Oatlands.

CHAIR - How long would that take?

Mr JOHNSON - It is probably a bit over two hours to get from Oatlands, but by the time the system worked through it was three-and-a-half hours to get to that patient. Another person wrote to me, saying that -[tbc]

> The lack of ambulance service in Cygnet was another reason I decided I couldn't go down to Tasmania from Queensland to live near my daughter.

So, people are making life choices on the basis of their ambulance experience. There is incredible frustration and a loss of faith in the service felt by people in the Huon. Again, I emphasise it is not frustration with the paramedics or the volunteers. People are questioning, do I even bother ringing, do I just jump in the car, do I risk having a further accident or incident, and should I even live in the Huon where I am going to be vulnerable to the lack of a service?

I have been contacted by five volunteers or ex-volunteers in this process and they are all experiencing the same frustration, or different frustrations. One stated to me, 'We are getting smashed with town work. Night shifts have changed, with many more stand-bys in Kingston.'. This is the practice in which the Huonville ambulance gets shifted to Kingston when the Kingston ambulance is called away and they wait on standby there rather than in Huonville. He further quotes:

> Once we're in Kingston or called into town, we are sucked into the vortex of town work. This means going to Collinsvale, Richmond, Geilston Bay or delivering babies in Glenorchy.

Dr SEIDEL - And these are volunteer ambulance officers from the Huon Valley?

Mr JOHNSON - That's right. These aren't paid paramedics. Obviously, there's a paid paramedic with them but the paid paramedics can't get around without the volunteer.

> Fatigue management is being affected and there is less coverage on the roster. Fewer people are putting their hands up. We don't mind getting smashed doing Huon Valley work, as that is what we signed up for.

Another recently retired 18-year serving ambulance volunteer related to me that the situation is getting far worse. She's just retired. Recently she rang for an ambo for her elderly mum suffering chest pain; the wait was five hours. Three weeks ago she helped an unconscious gent with a defibrillator fitted pacemaker who collapsed in the main street of Huonville, the wait was two hours. This is somebody with a clear medical condition. In the last years of her service she even resorted to using her own vehicle to attend to incidents.

However, one of her main concerns is the welfare and the care of the volunteers. The system is founded on them and if they are not there, then there is no service. She believes that fatigue management is not being addressed. No one is checking whether volunteers have recovered between their day jobs and their shifts or whether they have had adequate sleep. She is concerned that the system is relying on fewer and fewer people who repeatedly fill the gaps in the roster. She described to me one gent who, whenever there's a gap in the roster, he gets off his tractor from the paddock and he comes in and he fills that gap. That's what the system is being held together by.

But it's not just the ambulance volunteers, the Tasmanian Fire Service volunteers are supporting the system under me, the ambo volunteers. A member of the Huonville Fire Brigade advised me that they are being called on five to six times a year to provide support for medical emergencies. These are life-threatening situations; they get called on for those. And this is when ambulances are already unavailable because they're off doing something else. Following a lengthy communication process through Ambulance Tasmania and then the TFS, it's often 20 minutes before they even get into their truck to then try and get the first responder or paramedic. The person who spoke to me said that he'd been personally involved in three cardiac arrests, two of which the interventions were unsuccessful but one patient was saved.

Dr SEIDEL - It's a cardiac arrest call to triple zero, there's no ambulance and they're sending out a fire service volunteer?

Mr JOHNSON - From the fire service who are picking up a first responder or a paramedic, depending on who is available.

CHAIR - They find them wherever they can. They must be off duty ones, are they?

Mr JOHNSON - They are.

CHAIR - Do those people get paid when they do the job? This is a paramedic who's on a day off -

Mr JOHNSON - The paramedic, I imagine, would get paid but the first responder, if they are a volunteer, depending on their tier, their level within the service, they're a volunteer, they're not getting paid. And the person I described before, the 18-year serving retired person, that was the sort of thing that she would do and that she was doing in her own car in the end.

Dr SEIDEL - The volunteer ambulance officer would pick up, in her own car, a paramedic who is off duty to attend an emergency in the Huon Valley?

Mr JOHNSON - I'd need to clarify that. My impression from her was that she would then attend that. Okay. Or sometimes, she would, with her own vehicle, go out to that emergency because there was nothing else there.

Ms LOVELL - And is that coordinated through Ambulance Tasmania or is it more an unofficial network of people who know each other in the Huon Valley so they know who to call and do it because there is no one else?

Mr JOHNSON - I don't know the answer to that. I would imagine it's through Ambulance Tasmania. I know that she had a pager.

CHAIR - If that's the case, Ambulance Tasmania know about this.

Mr JOHNSON - Yes.

CHAIR - Has Ambulance Tasmania had any conversations with the community about this?

Mr JOHNSON - No. There's been no direct communication with the community on this and our lack of coverage.

CHAIR - What about through the volunteers?

Mr JOHNSON - I know the volunteers have that connection. They are voicing their concerns internally but they have been voicing their concerns for a number of years and it is going nowhere.

The Huonville Fire Brigade officer advised me it isn't just the Huonville Fire Brigade, it is the other fire brigades in the Huon that are being called on. He said it is likely to be 10 or 12 incidences across the whole of the Huon where the TFS backs up the Ambulance Service.

Dr SEIDEL - Per year?

Mr JOHNSON - Yes, per year.

CHAIR - Roughly one a month?

Mr JOHNSON - These are extreme situations. They are called out in life threatening situations. He also volunteered that they are prepared to provide further support in non-life-threatening situations because that is just who they are. He advised that they had an off-road capable vehicle, a four-wheel drive, that was fit for purpose but Ambulance Tasmania have taken it away from the Huon.

CHAIR - Who had that vehicle?

Mr JOHNSON - I think it was kept at the ambulance station but it is now not there so if they had to go out into the forest or somewhere remote they have to use their own TFS vehicles or an ambulance because that four-wheel drive is no longer there.

On a good news front, in response to the urgency that we have down there is a group that is having their first public meeting on 18 October. They are a group between Cygnet and Gordon on the very south coast of that peninsular. They're endeavouring to get their own volunteer ambulance corps with the ultimate aim of having their own station, probably based in Cygnet, but somewhere that could service them. They have been frustrated to some extent by Ambulance Tasmania in doing that, I guess because Ambulance Tasmania know that they can't support it.

CHAIR - They could. It is a decision that you make.

Mr JOHNSON - Yes. As I said, they're having an information session on 18 October. I'm wondering whether the people who go along will be told just what to expect, that in volunteering to help their local community they in fact will probably get sucked into the vortex of town work; that instead of supporting the community, they will end up underpinning the metropolitan service.

At the beginning I read out lots of examples and I did so because how would you know what the situation is like because we do not have published data to tell us what the call out times are. There are no performance indicators against which the service can be measured.

Google told me last night that at 8.52 p.m. in Franklin I was just 38 minutes from the Royal. Even though we are not the back of beyond, in an emergency it could be three to four hours or more before I could be transported to the Royal.

CHAIR - Before the ambulance arrives?

Mr JOHNSON - Before the ambulance arrives and then you have to go back. Hence, do I get my wife to put me in the car or do I put my wife in the car? Many of us wonder when we come over Vinces Saddle into the valley whether our health outcomes matter a bit less than others. Should the regional unpaid volunteers be used to underpin the Hobart service at the expense of their local communities? What should a reasonable call out time be for a person needing emergency care in Cygnet, in Judbury and Mountain River and Huonville? How long should we expect to wait? The situation is only likely to come under more pressure.

A Huon Valley Council report shows that there is demand for 700 new homes in Cygnet and the council is very keen to meet that demand. Port Huon already has a residential zoning capacity for an additional 1500 homes. What should happen?

As a first thing I think we need to measure the callout times and we need to measure the outcomes of those callouts. I am sure the data is there. It would be easily retrieved. We can find out what the situation is and then let's set agreed standards that must be met. We don't expect to have an ambulance on every corner. We understand that if Huonville Ambulance is called away, then it is tough luck that you need an ambulance.

CHAIR - But if it is called away to sit in Kingston to do town work that's a different thing.

Mr JOHNSON - That's exactly right.

Ms LOVELL - Then it's called to Glenorchy or Cambridge or places they get called to.

Mr JOHNSON - Let's resource the service so that the standards that we set are met. We don't expect them to be the same standards as the metro, and I don't know what they are, how long the ambulance service is required to get to a call out but we need to know what that standard is. As a first step the practice of sending the Huonville ambulance to Kingston on standby needs to stop. It's having a deleterious effect on the fatigue of the officers, both paramedics and volunteers. I am told they can be woken at 1.30 on a Sunday night, 'We need you to go to Kingston'. They may not get a call out from Kingston and then they just drive back to Huonville.

The person I described who talks about getting smashed, he tells me that - and this is a fit young man, a footy coach at Huonville - it has taken him two days to recover from a shift.

CHAIR - Physically or mentally, or both?

Mr JOHNSON - Probably both. He is a single dad. On Sundays he wants to be with his girls and he's going, 'Do I do the ambo, or do I see the girls?' Of course, he is going to see his girls so that is putting more pressure on the number of volunteers that we have.

Dr SEIDEL - How difficult do you think it must be for this person who is probably thinking of resigning as a volunteer ambulance officer but also knowing if he's resigning there will be even fewer officers there who could serve the community? Is that something you've come across as well?

They are health practitioners in their own right. They are put in a very difficult situation, aren't they?

Mr JOHNSON - Yes. In talking to these people, they go back. Both of them mentioned that the same chap who gets off his tractor and holds the whole system together by putting his name on the roster where there are gaps.

CHAIR - He is the one who needs the ambulance.

Mr JOHNSON - Yes. We need the Government to be honest with us. If they can't provide it's going to be 20 minutes, it's going to be 30 minutes, it's going to be 40 minutes, whatever the number is, they need to tell us so that we can make our life choices based on that clear information. Most of the time when you ring an ambulance you expect to be seen pretty quickly. It ought not to be five hours when you have an excruciating abdominal pain that you think might be a ruptured appendix and you wait from 2 a.m. from 7 a.m.

CHAIR - I can tell you they don't keep those long waits because I asked about the Smithton Ambulance Service in parliament recently and it was a very inadequate answer. They don't record those things.

Mr GAFFNEY - Are you familiar with the Community Emergency Response Team (CERT) program run by Ambulance Tasmania?

Mr JOHNSON - No.

Mr GAFFNEY - Perhaps it is worthwhile having a discussion. There are four of them in Tasmania: Poatina, Longford, Port Sorell and South Arm. It's where they have volunteers who have a community car and they go to the place and they take on the role of the ambulance until the ambulance arrives so at least there is some help there. In Victoria there are 29 of them with 450 different - There are models in Tasmania.

I am not saying the ambulance shouldn't get there on time but there are other communities that have similar issues even in Port Sorell getting an ambulance in time. That's been running since 2008 or 2009. There are other models that may not assist the ambulance time but communities have looked at this because they have had the same situation.

Mr JOHNSON - Informally, that is what is happening with the first responders when they're getting that call one, two, three steps down the line when other levels aren't available. It is also something that the group which is meeting on 18 October, it might be a model they could adopt.

Mr GAFFNEY - The first responder is the first person there then they look at the ambulance after that. It is on the Ambulance Tasmania website which those communities found because they were having the same issues.

Mr JOHNSON - One of the things that the retired officer spoke to me about was she became reluctant to say that she was a former volunteer officer because it seemed that as far as the communications, everything would be okay because she was there so it went further down the list of priorities. I fear if we have something like the CERT system in place, which is good. Communities ought to get together and fix their problems, but that will be seen as a default. It is like a stopgap, we don't need to get to that one yet. I will certainly mention it to that group.

Mr GAFFNEY - I know the Port Sorell one. I am very familiar. They have set that up at the local fire brigade so it is part of that service 24/7 arrangement with all the communications and the car and whatever to get to the area quite quickly.

Mr JOHNSON - I will speak to the Huonville Fire Brigade. Maybe that is the sort of umbrella they are operating under as well.

Dr SEIDEL – You have seen the community grow over the years, where it is now Franklin, Geeveston, even Dover, more people are moving in. Businesses are expanding, the aquaculture industry for example. Have you seen a change in the ambulance service level in terms of how many ambulance stations we have, how many paramedics we have or even how many volunteers we have or has it been pretty static?

Mr JOHNSON – I would say it is static. It certainly hasn't grown. It has not grown with the expansion of the population. It has not grown with the expansion of industry and the risks attached to that industry. I know that there have been some moves in the Dover area to improve the service there and that is based around a helicopter service.

Dr SEIDEL – A helicopter pad.

Mr JOHNSON – Yes. That is the extent of it. I have a letter here from a Dr Helen Whitney from Southport who expressed her frustration in a letter to the then minister in February this year, about what was being provided to Southport. Interestingly, she did not receive a response.

CHAIR - In terms of ambulance services, you are talking about?

Mr JOHNSON - Her question was about emergency responses and her community proposed a whole range of measures to deal with it but they didn't receive a response from Government.

CHAIR – How long ago did they write the letter?

Mr JOHNSON - February. There has been a change of minister and we have had an election in that period.

CHAIR - The Government is still there.

Mr JOHNSON – I will table that if that is okay.

CHAIR - If you wouldn't mind that would be great. That is probably enough shocking news for today. We have run slightly over time, Shane, but is there anything else you wanted to add in broad terms or anything else you think it is important for the committee to know?

Mr JOHNSON - Some concrete changes, some clear change of direction would be great.

CHAIR - With regard to the Huonville Ambulance Station, is that a paramedic station?

Mr JOHNSON - Yes.

CHAIR - A dual paramedic station, two of them are placed there?

Mr JOHNSON - Yes.

Dr SEIDEL - Which is a paramedic plus a volunteer.

CHAIR - So they have two paramedics at all times?

Dr SEIDEL - I am not sure how many. There has to be one volunteer and a paramedic on all the time.

Mr JOHNSON - There is only ever one paramedic there at any time.

Dr SEIDEL - It is a combination of paramedic and volunteer.

Mr JOHNSON - With the growth of Cygnet particularly, it makes sense to me that a station is created in Cygnet and that would then become the Huonville backup.

CHAIR - Or the Cygnet station.

Mr JOHNSON – It would be the Cygnet station but the Huonville backup when Huonville is out and even if it is ramped at the Royal.

CHAIR - When you think that the geography of the area and I am not overly familiar with it, but I have been down that way. We have heard representations today and also when we went to visit the Dover Medical Centre of additional housing for 50 people who are long-term homeless people for example, and they often come with complex needs because of their circumstances, and so they are more likely to rely on ambulance services too. You are pushing people further down the valley. It seems that these decisions are being made, as we saw in Queenstown when they put the quite frightening mountain bike trail in without any review or consideration of the existing health services. It seems this is what is going on. There's no coordinated approach.

Dr SEIDEL - There is no health service impact assessment.

CHAIR - Yes, that's right. They might do a traffic impact assessment on some of these housing developments but you really need a service, and education, potentially, too. It takes a much more holistic approach to these sort of decisions. Yes, we're trying to fix the housing problem, and we should, but we also need to look at that in a holistic way, the same as health services should be looked at in a holistic way.

Mr JOHNSON - I'd certainly like to see a recommendation that, to begin with, we measure the system and set the standards and the KPIs that need to be met. Then, the community knows where they stand with their government.

CHAIR - Thank you very much for appearing. We appreciate you taking the time to share the views of many in your community and their lived experience, which can sometimes be difficult for committees to get on the record. We do appreciate that, and if you could table that document, thank you.

THE WITNESS WITHDREW.

The Committee adjourned at 12.16 p.m.