PUBLIC

THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION 'A' MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON FRIDAY 21 SEPTEMBER 2018

ACUTE HEALTH SERVICES IN TASMANIA

Mr TONY BRADLEY AND **Mr MICHAEL JACQUES,** COLLEGE OF EMERGENCY NURSING, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - Welcome to the hearings. This is the Government Administration A Subcommittee Inquiry into Acute Health Services in Tasmania.

The hearing today is protected by parliamentary privilege. Anything you say is protected by parliamentary privilege, but I remind you that any comments you make when you walk out that door to the media may not be afforded that same privilege. There is a paper providing information for witnesses. Are you aware of that document?

Messrs BRADLEY and JACQUES - Yes, it has been sent to us.

CHAIR - Okay. The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available; the hearing is also being broadcast today.

The way we will run the hearing is that you have the opportunity to make an opening statement if you care to do that, and then members will ask you questions. If at any time during the hearing you feel you need to say something to us confidentially, you can let us know that. Committee members will have a short discussion and we may proceed in camera if you wish to do that. I just let you know that opportunity is there.

Mr BRADLEY - Thank you for letting us come before you today. The current president sends her apology. She is unable to make it as she is in the north-west. We are both past presidents of CENA. Michael stepped down this year and I was the president before that. We welcome the opportunity to come today to talk and to answer your questions about how the college sees the state of health services in Tasmania at the present time.

Our submission to you is broken into Launceston and Royal Hobart. They are two different stories. There is a lot of difference between the two places, but certainly we look forward to your questions.

When you look at the predicted presentations on the first page, what we predict for the future is quite conservative: a 1.3 per cent increase per annum across the state. I know the Royal is looking at 3 to 4 per cent. We have a slight downturn at the present time, which is probably attributable to the fact that there is no flu at the present time. There are two stories within our submission as well.

We look forward to your questions.

CHAIR - Excellent. For the record - I do not think we have had it expressed before -with respect to level 4, can you explain what level 4 is, what the process is and what it involves for nurses on the ground?

Mr BRADLEY - The college does not get involved in level 4 escalations. We can answer questions related to the college. Level 4 escalation is something the Royal Hobart has.

CHAIR - No, just the mechanism. You would be aware of the mechanism?

Mr BRADLEY - The mechanism is that they look at trigger factors and whether we meet certain triggers; it is then discussed at high levels as to whether we go to a level 4.

CHAIR - And a typical level 4 would involve?

Mr BRADLEY - The emergency department under extreme demand with loads of ramping, maybe not enough discharges across the hospital to meet the demand of that day.

CHAIR - What does it means on the ground in an emergency department? Does it mean that you do not deal with non-urgent cases? Do you go to the urgent? Can you give us a bit of an understanding?

Mr BRADLEY - We always still go to the urgent. From the Royal's point of view we are split into two different areas: a mountain and the river. The mountain area is where people can walk in and be seen - basically, people who do not need a bed to be seen - and then the river area is where people who need an actual bed can to be assessed and treated, which includes our resuscitation area. We would be looking at a level 4 when all those beds are taken up by people either waiting for admission or fully admitted patients and our resuscitation room is full, or one resuscitation bed is available to be able to take a resus. from the community, plus ambulance ramping.

CHAIR - Under that sort of a situation in any hospital, what are the levels of risk? Is it that those with higher acuity are really at major risk or medium risk?

Mr BRADLEY - The risk starts in the community. If we have loads of ambulances ramped the risk is that there are not enough ambulances on the road to attend to emergencies. At worst times we have had up to 10 ambulances ramped, which means there are 10 ambulances that cannot get out to the community calls. If they get an urgent call, we then try to shuffle the deck chairs to move people around, but we are always doing that as part of an emergency department to get the people in.

The main risk is in the waiting room because at least with the ramped patients they are with an ambulance officer or a paramedic. The main risk is in the waiting room where patients are there with a relative. We have clinical initiatives - nurses across the state who care for patients in the waiting room - but at that sort of a level, you could have up to 30 people in the waiting room that you need to look out for.

CHAIR - Under a level 4, would nurses be called in from other locations in the hospital where they are attending to less urgent cases themselves?

Mr BRADLEY - At level 4 escalation meetings get cancelled and clinical nurse educators or non-clinical nurses are sent to areas of need if required.

CHAIR - Thanks for that. I really appreciate that.

Mr FINCH - Tony and Michael, how long have you been nurses in the system?

Mr BRADLEY - I have been a nurse for 25 years and that has all been emergency nursing.

Mr JACQUES - Fourteen years, all emergency nursing with a short stint in ICU as well.

Mr FINCH - You both have a lot of experience in nursing and in the emergency situation in Tasmania?

Mr BRADLEY - Yes, and I have worked in England and Queensland as well.

Mr FINCH - Do you have a sense of changes you might have seen through that time that have brought us where we are having an acute health inquiry in Tasmania? Was something like this needed 25 or 14 years ago or have we reached this stage because of those things you have highlighted in your submission?

Mr JACQUES - When I first started there was not a lot of innovation in emergency medicine with regard to models of care and the way we process patients throughout the department. There was a lot of initial leadership that went on in looking at lean thinking and different approaches such as taking the Toyota model into the emergency department, maybe that would work. It has had hits and misses. Over the last 14 years I have been a nurse, the emergency department has had so many different changes to its models of care in the types of nurses who have different roles within the emergency department, the types of medical staffing, increases in staffing.

At the Royal Hobart Hospital we have minor injury area, 'the mountain', and an acute area. That is the way we manage our workload. The patients who used to wait a long time for basic emergency care for minor injuries and who were put on the lower acuity of our system are now seen within an appropriate time frame. Sometimes we cannot achieve those time frames but areas of innovation we have had over the last 14 years have changed the way we work and made emergency nursing and emergency medicine much better.

Some of the things you do not see as an emergency nurse are the changes within a ward. We don't tend to step out of our little boundaries and some of those things are hidden from us. I don't see that level of innovation externally. Now is a great opportunity to look at how the inpatient units can manage their own workloads and maybe innovate more locally to facilitate things like flow and patient off-load from our perspective. When we get full, we cannot bring in more patients to see them and treat them. It puts more pressure on our staff and it leads to increased burnout and retention recruitment issues, just within the emergency department.

Ms FORREST - We had the ACEM representatives here a couple of weeks ago. I asked them about this because, having worked in hospitals for a long time myself and in all areas, we have seen change in the way the departments of emergency medicine operate, with innovative practices, trying to improve the flow, seeing people and getting to the right place more quickly. We have seen change in the surgical wards with flow and there has been some improvement in

that. Part of that was due to having a surgeon in charge, making decisions and seeing patients on admission - the surgeon, the consultant, and not only the junior resident, for example. That doesn't seem to happen in the medical ward.

You may not be able to comment, not having worked there. If there were more innovation in the care of the medical wards - for example, it has been suggested to me it might be helpful to have a specialist physician whose job is to manage the medical patients, whether they are in the medical ward, ICU and some in the DEM, and bring them down there to sort the DEM patients out.

In terms of what you see in bed block in all three hospitals - I know there has been bed block in Burnie recently, which is a bit new, as far as I understand -

Mr JACQUES - I have worked in all four hospitals.

Ms FORREST - Your experience in Burnie would be interesting. I am getting calls from patients who cannot get beds for surgery.

Where is the backlog in DEM? Are they medical or surgical patients? In your submission on page 2, you say that 53 per cent of the state's ED presentations are category 4 or 5. An ACEM representative said they are not the major problem because you can fix them up and send them out.

Mr JACQUES - Yes, but they still take up workload of the emergency department.

Ms FORREST - That is right. Where do you see those problems and which areas do we need to focus on down the chain?

Mr BRADLEY - That is where it comes into the different areas. I know Launceston has more, predominantly category 4 and 5s, than what we do. The 4s and 5s we get in the Royal Hobart Hospital are less. They are the sort of 4s and 5s you want, who need to come and see us. That is where there is that little bit of mix-and-match. We have a great GP service in the south and people can still get into a GP and get onto their books.

Ms FORREST - It is problem in other parts of the state -

Mr BRADLEY – Yes, certainly. When we opened up the short stay unit with Commonwealth funding quite a few years ago, it was part of the deal in which people who came into the short stay unit in emergency were then allocated a GP if they didn't have a GP. We were able to ring up and get them onto the books or give them a list of GPs who were taking patients. I don't want to bring up the north-south divide, but there is a little bit of difference between the north and the south.

Ms FORREST - It is a relevant point. People can't get into to see a GP and they end up in the DEM. As far as the non-4 and non-5, the people who need admission, where is the backlog in moving them through?

Mr BRADLEY - It is predominantly in medicine and psychiatry.

Ms FORREST - That confirms the need for a review of way flow in medical wards works?

Mr BRADLEY - There is good work being done on the medical wards, certainly around patient care. They are doing a lot of good work on the wards in those sorts of things; protected meal times and that sort of stuff. The thing that really slows medicine down, and I have probably noticed this across hospitals I have worked at, is the safari round. You have a medical patient who is stranded on the surgical ward or on the oncology ward or down in the -

Ms FORREST - Because they cannot fit into the medical ward.

Mr BRADLEY - Yes, because there is more of a demand or the acuity is high in some of the other medical wards where the discharges are slow. That then falls back down. Research shows that you spend longer in hospital if you are waiting longer in the emergency department for a bed.

Ms FORREST - That is hard to deal with if the beds are not there and they are available somewhere else. You have to put the patients where there is a bed.

Mr BRADLEY - Which is good for us but it creates that extra problem.

Ms FORREST - One of the other suggestions made is that a lot of medical patients are still in a hospital bed waiting for something and can't be discharged. Is there a better way, in your view and having worked in wards and seen how wards operate, of dealing with patients who are just waiting for something?

Mr BRADLEY - If they are waiting for a scan and it is not an urgent scan for something that is life-threatening but they are ready for discharge after the scan or otherwise, if they can be discharged and guaranteed the scan the next day as an outpatient - because as soon as you go onto the outpatients list it is a longer list - if you can be discharged, but know you have a scan appointment for the next day, an ultrasound, a CT, an MRI or whatever it is, that would free up a bed for the night.

Ms FORREST - Knowing you are not going to get bumped for something else, that is the challenge, isn't it?

Mr VALENTINE - Wouldn't that depend on where they live? That would be an extra cost for them if they are coming from Queenstown to north-west region.

Mr BRADLEY - That is right.

CHAIR - If we could provide motel accommodation for them, it is going to be cheaper than keeping them in the hospital for a night?

Ms FORREST - There is the option of a step-down facility, when they do not require that acuity of care or they don't need much care at all but need something before they go home.

Mr BRADLEY - They may be fit for discharge but need a scan to see what they are going to do in the next process of their treatment, yes, if they could be discharged and guaranteed a scan the next day.

Ms FORREST - Do you think hotel accommodation would be suitable for that sort of thing?

Mr BRADLEY - Yes, until you get into the Christmas/New Year period and you cannot find a bed. That is another difficulty. Perhaps it is worth seeing if they have relatives nearby or something like that. The proposals were around about building a new hospital or redeveloping the RHH, there was that medi-hotel type of thing. If you use Ronald McDonald House as an example, something like that could be used as a step-down and would be ideal. The medi-hotel proposal was great. They are the sort of people we could put in there, as well as relatives who have come in from interstate to see somebody who is dying in ICU. That was a great idea. A step-down facility of some sort would be good.

Mr VALENTINE - Following up on the low acuity, the level 4 and 5, is that right?

Mr BRADLEY - Yes.

Mr VALENTINE - It has been suggested in the public domain, perhaps in a letter to the editor, that GP services ought available at the RHH. Can you comment on that and the benefits or detriments to a process like that?

Mr BRADLEY - I think we could both could comment. I have worked in hospitals that have had GP services at hospitals. What usually happens is that one person puts their name down in one spot and then they put their name down at the other and wait to see who gets called first. Technology is great - 'Come on over, you have just been called.' It does not actually improve decreased presentations. It has been proven across many places it does not work.

CHAIR - It makes it all more complex.

Mr BRADLEY - It does. Certainly, the nurse practitioner model -

Ms FORREST - It is a better place for nurse practitioners?

Mr BRADLEY - Yes.

Mr JACQUES - It is fantastic model for nurse practitioners. Essentially, it is our bread and butter. Because of overcrowding, sometimes some of the acute flow enters our area, which is not optimal. It makes it a little tricky for us to manage, but we have fantastic staff to be able to work care.

One of the other things is GPs are a fantastic resource of realising when their limitations are met. The Royal has just about every service at its fingertips. I do not get many GP-inappropriate referrals. If there was one locally, there would be a lot more netting and they would discharge and refer to the emergency department for a lot of things coming in already.

It is not a matter of putting more GPs out there and trying to minimise the 4s and 5s coming through. Many are coming back for next day surgery for minor injuries. I do not know if that is necessary. Yes, for some things, but not all.

CHAIR - Is there a trend in terms day and the time of day these extras are attending at categories 4 and 5? Friday and Saturday nights would presumably be increased.

Not being able to see their GPs because they are simply not on deck at the time. Do you have a comment on that?

Mr JACQUES - I put through a nurse practitioner model maybe six years ago. The peak times were between 11 a.m. and 6 p.m. There were two peaks. Around those times a high amount is sometimes variable, but they seem to be the trends.

Days of the week: oddly Monday seems to be the busiest day, but you cannot tell. Some Sundays are the worst days I have ever worked, as are some Wednesdays. Picking a particular day of the week, it is unpredictable but certainly time of day for peak presentation is 11 a.m. and 6 p.m.

Mr BRADLEY - Certainly on the weekends it is sporting injuries and worker injuries during the week.

CHAIR - Or party injuries?

Mr BRADLEY - Training injuries and things like that. You could have somebody who goes to a GP surgery with a cut finger and we explore if a tendon is nicked or needs some plastic reconstruction. Those are the ones that, even though they are category 4 or 5, are not life-threatening but need some sort of hospital intervention.

An emergency department is looked at as a one-stop shop. You get your bloods, you get your X-ray and know straightaway. We are in a day and age of, 'I want to know if my ankle is broken or is it sprained'.

Mr JACQUES - You cannot get that anywhere else in the community now.

CHAIR - I notice in the attachments it talks about the younger age group presenting more particularly with some of these 4s and 5s. Do you think a lack of education is causing this to happen or is it this instant need to know?

Mr BRADLEY - There is the Launceston thing too. Those figures are from Launceston rather than from down here in the south.

CHAIR - So there is not that trend in the south?

Mr JACQUES - No. It is across all ages and certainly health promotion should be something we should focus on, but we cannot do it from an emergency point of view.

They have tried TVs with health promotion stuff on there, like influenza and gastro information. Some people would sit down, look at that and then leave. I do not know whether it is necessarily a great thing. Certainly, health promotion in the wider community is something we could definitely do.

CHAIR - Is it called 'the doctor service' that exists?

Mr JACQUES - Yes.

CHAIR - Is this being utilised enough and maybe why you are getting these extra presentations of that age group?

Mr BRADLEY - Since that started we have not seen much change.

CHAIR - No.

Mr BRADLEY - The only change I know from our point of view is we are not getting the flu at the moment. We still get referrals from the after-hours people. It is a very limited service, but if you then look at the after-hours service at Moonah, they sometimes have a few hours' wait there also. If you are going to wait and may need a blood test or if you are not sure if it is a tummy bug or your appendix, you are going to come to the hospital because you know this is where you are going to get that service from. Certainly, when we say we have a lot of 4s and 5s in the south coming in, do not get me wrong: there are not many who should not be there.

CHAIR - No, especially when you have things like meningococcal and people presenting with a rash or whatever - they need to go and find out whether it is. They are not going to find that out at their GP.

Mr BRADLEY - Yes, and certainly a simple presentation could turn into meningococcal.

Mr FINCH - I wanted to continue on that personal side of things, Tony - your story in respect of the changes you have seen over your 25 years. I am trusting that as the changes have come about, there have been improvements in the circumstance and where we are now. What things might occur in the future that might make the job of nursing less confrontational, more of an environment in which you feel you are fulfilled in your work? Can you tell us something about your journey?

Mr BRADLEY - Certainly over the 25 years, back when I first trained, there was not anything called access block. That was not something you talked about when you worked in emergency departments. It was not until I worked in the UK, where I saw a fair bit of the access block word being talked about or blockages and overcrowding of emergency departments. They were the first times I felt really stressed as an emergency nurse. I was working in really tough conditions in very old buildings where there was not enough space to get to the number of people coming through. Both hospitals I worked at were tertiary level hospitals, so major hospitals over in the UK. It was then I thought, 'Wow, I hope this never, ever happens in Australia.' When I came back is when we started seeing it all happening in Perth. Perth did all the really good work around the 3-2-1 or the four to four-hour rule. They did all this good work but if you now look at Perth, they are not the ones leading the way. Queensland is now the one leading the way in terms of what they are doing, especially the PA Hospital where they are a magnet hospital,

CHAIR - A magnet hospital?

Mr BRADLEY - A magnet hospital.

Ms FORREST - They take people from everywhere.

Mr BRADLEY - A magnet hospital. It is an American status hospital. You meet certain safety and quality goals and have certain things in place where a lot of the decisions are made on the ground level. There is a lot of input made on the ground level that feeds its way up rather than feeding its way down. Safety and quality is a big thing. I am not saying safety and quality is not one of the big things in Tasmanian hospitals; it certainly is. Certainly quite a few of us have gone

through accreditation this year and recently. Yes, it is a magnet hospital, the PA, and, using the analogy of tenpin bowling, it is knocking over quite as few pins, which is great.

I felt we were on track when I moved to Tasmania. It was a quite dynamic place to work. Set up the nurse practitioner service in the emergency department and obviously that was going to blossom but then it just stopped. We are not flourishing any more. We have had a hell of a lot of people come through and do reports on the emergency department, reports on patient flow activities, all that sort of stuff, but we need to now really start putting a lot into action. It is a broader thing. We need to involve the university if we are going to look at the University of Tasmania - it needs to provide an emergency course that gets nurses ready for resus.

Ms FORREST - You are talking about a specific nurse practitioner or emergency nursing course here?

Mr BRADLEY - They have the postgraduate certificate, and straight through to the Graduate Diploma of Emergency Nursing. We do not have any nurse practitioner courses in Tasmania. That was one of the main reasons I moved to Tasmania - I felt as though it was at the grassroots. There was only one nurse practitioner at that time

Ms FORREST - If you were the minister, what would you do in terms of nurse practitioners to make sure they are utilised to the fullest capacity and taking the pressure off other areas? Where would you start and what would you do?

Mr BRADLEY - I think we need to look at it across the nursing career structure. Nurse practitioner - it takes quite a while to get here, but there are quite a lot of people who could probably take that step. It is now a common thing in other hospitals to have nurse practitioners. The RHH has two FTEs of nurse practitioners in the emergency department, but more would be great to deal with the workload. We need to look at the equality of nursing structure across the centres. There is a little bit of an imbalance as to what different hospitals have in terms of career structure within their emergency departments, and I think that is one place that we could start. We could see some cost savings that way, but certainly I would look at the career structure provided in each emergency department.

Ms FORREST - UTAS does not currently offer that?

Mr BRADLEY - UTAS does not offer a nurse practitioner course. They offer a postgraduate certificate of emergency nursing and a graduate diploma of emergency nursing which leads on to a masters of nursing.

CHAIR - Did you say certificate in emergency nursing, not degrees?

Mr BRADLEY - Postgraduate certificate.

Ms FORREST - What is the difference there? I am trying to make the differences clear for the record.

Mr BRADLEY - We need a more clinically approached postgraduate certificate so that people come out with resus. skills and are right to work in resuscitation from having a postgraduate certificate. Certainly a lot of other hospitals do not let a nurse work in resuscitation unless they have a postgraduate certificate. We cannot afford that; we train our own. A lot of

people have done the postgraduate certificate but do not work in resuscitation. I think we need to have some of the services set up and make the end goal of a nurse practitioner an option. That means having nurse practitioner candidate positions created alongside a nurse practitioner course of some sort.

Ms FORREST - The nurse practitioners who work in the DEM, can they order investigations and bloods and things like that? Is that helpful? Can you talk about that a bit?

Mr BRADLEY - Definitely. They work through most of the 4s and 5s. There is the odd cat. 3 and 2 that they will see if they meet certain conditions and they work within their scope. Michael is one and I was one. We saw we made a difference. We are not going to keep it quiet but there was a bit of a backlash about us taking work away from doctors. What we are finding now is that orthopaedic registrars, ophthalmology registrars and all those sorts of people like the quality of work they put through and it is the quality of the doctor.

CHAIR - These nurse practitioners have tertiary training and on-the-ground experience preferably and they sit between the medical officer and general nursing. Is that what you are talking about just for the record?

Mr BRADLEY - Yes, they are still overseen by a doctor and then you have the nurse practitioner. As you say, Ruth, they can order tests, order X-rays, make the diagnosis, discharge the patient -

Ms FORREST - Is there any prescribing?

Mr BRADLEY - Prescribe as well.

Ms FORREST - Limited prescribing, I assume?

Mr BRADLEY - No, we are lucky enough to have got through full prescribing.

Mr JACQUES - Within your scope. Everyone's scope is slightly different. I am not going to administer anaesthetics to put someone to sleep for a procedure. Within my scope, there are set things you can prescribe and it is quite an exhaustive list because you need to have a good cross spread.

CHAIR - How is this received by the medical profession? Are they supportive of this happening or not?

Ms FORREST - They are now.

Mr BRADLEY - As a manager they come to me now saying, 'Where is my nurse practitioner today?' It is 'my' nurse practitioner.

Mr JACQUES - I think it is best said, one of the senior doctors said, When you first started, I was a bit apprehensive about nurse practitioners and I must admit I have changed my tune and I want to ask you one question if I can.' I was, 'Yes, sure'. He said, 'How do we get more of you and that is a big thing because I was your biggest barrier to growth, personally and professionally.'

Ms FORREST - It is a trust thing isn't it? It takes time.

CHAIR – Well, of course it is.

Mr BRADLEY - It was tough at the beginning, really tough. Then we felt as though we were flourishing but then there WAS no talk about it anymore. I was relieved to hear they are looking at hospital in the home and that could be a nurse practitioner-led service.

CHAIR - Your communication with, say UTAS, with regard to this: have you discussed what they are providing and what they could be providing?

Mr BRADLEY - The college has approached them and has asked them to change their postgraduate certificate course to make it more about needing to meet some clinical skills.

Mr JACQUES - As an example, once you have finished as a nurse, to go onto specialty training you do a postgraduate course. It is a postgraduate degree certificate in the area of specialty. It is emergency medicine for us. Nationally they all vary slightly, but the content is the essentially the same. We would like to see those certificates given to people who meet a set requirement. They can work in all areas of the emergency department - triage, resuscitation, a minor area and all those things - with a high degree of skill. If you are getting a certificate in our specialty, that should be the baseline - it should be the bare minimum - and then you are growing towards mastering those areas.

The nurse practitioner is different. You still work through that pathway but you do a minimum of 5000 hours in your specialty of advanced clinical practice. That is not nursing; it is the blurry line between nursing and medicine and then a masters in that area.

Ms FORREST - You have to have a masters to be in that area?

Mr JACQUES - Yes, it is minimum requirement through AHPRA. It is an arduous path.

CHAIR - Does that include experience on the ground?

Mr JACQUES - Yes, a minimum of 5000 hours, whatever that looks like, of advanced clinical practice. That is not nursing practice. I can't rock up to work and do my nursing role and have that attributed to those 5000 minimum hours. Most of us do tens of years.

Mr BRADLEY - It is hard here because we don't have candidate positions. If we had candidate positions, they can get those 5000 hours in a candidate position and can go the AHPRA and say, 'Here is my evidence I have done the course, here are my hours - give it to me.'

Mr JACQUES - Like most people, I cut back work and came in on my own time as a student. I was working over a full-time workload to complete both university study and working to try to keep up with life in general.

CHAIR - How many available positions in the hospital would be ideal?

Mr BRADLEY - We could probably increase ours to at least five FTE.

Mr JACQUES - I think it is six just to cover a roster.

CHAIR - Sorry, I am talking about in the training sense, being available.

Mr BRADLEY - Across the state or in Hobart?

CHAIR - Across the state.

Mr BRADLEY - We would like to see it across the state. I think that would help smaller hospitals, like Mersey and North West Regional Hospital, and it is working in Mersey. It is working in Launceston and it is going great guns with us in the south.

CHAIR - Looking at that upward trend of attendances, it would assist every hospital in future.

Mr BRADLEY - It is one of the answers.

Mr FINCH - I was interested in the way you laid out the input, throughput and output in your submission. It gave us some idea of the complex issues you are confronting in the emergency department. Point 6 you made, that community services for mental health are lacking and the ED is not the best for the majority of mental health presentations. Can we explore that and how that might be solved or mitigated, perhaps to relax that stress that comes with those patients?

Mr BRADLEY - Certainly. All the answers do not lie in the hospitals. It is health, broad spectrum. There need to be community services and general practitioners who can refer people in the community too, rather than trying to come to the hospital first to access the services so they can get out into the community.

It is the same with mental health. Mental health is not an ideal spot for presentations to an overcrowded emergency department. A separate psychiatric emergency centre, especially in the south, would work well because our numbers in the south are a lot more than they are in the north. Having spoken to the NUM there, their presentations are not as many as the Royal Hobart Hospital. It is getting the right things in the right spot. If the Royal Hobart Hospital is the tertiary referral hospital, it should have a separate psychiatric emergency centre. We are probably at a stage we could look at having a separate children's emergency department as well.

CHAIR - Is it something the Peacock Centre is looking at providing?

Mr BRADLEY - Talking about it would help but even the presentations would be nice if they could present to a separate, purpose-built area - they would feel much safer and the surrounds are right for them. If it is a mental health presentation such as an overdose that needs to be medically cleared first, then obviously that would need to come to an emergency department so that we can medically clear them before we pass them onto mental health. We would have to work out how we transfer these people to that area. It is a broad thing and everyone has to pop in ideas about what they can do in the community, what we can do in the hospitals and what we can do in between.

Mr FINCH - Yes, I can imagine if there are those peak times and people come with a mental health presentation it could be quite confronting, stressful and not a good place to be. We have had reports recently of people having to wait a long time to be helped.

Mr JACQUES - That is a blend of different things, external pressure from bed block and ramping, and trying to get our acute patients through that system. The psychiatric presentations are not all acute. They are managed in a triage-based system. Yes, it can take time to get through that.

CHAIR – On the emergency department's overcrowding and access block, on page 12 of your submission you talk about safe monitoring and senior medical review of all patients on the ramp being something that needs to occur. How severe is that issue?

Mr BRADLEY - There is a lack of privacy. It is a corridor. You are practising medicine in a corridor, asking personal questions in a corridor. Yes, the senior medical officer will go out and review them and order any tests to start the treatment but we get into that grey area of treating them in the ramp. It is the lack of privacy.

CHAIR - In a community like the north-west, where the person they may be sitting next to may be related or -

Mr BRADLEY - Hobart is a small town, too.

CHAIR - It is probably more acute in a smaller community. I am not only pointing out the north-west. That must be an issue.

Mr BRADLEY - The lack of privacy is the big thing and we are practising nursing and medicine in the wrong spot.

Ms FORREST - You may be exposing them for a procedure; it might be a relatively minor procedure, but they are potentially exposed to someone they don't know at all and that is as confronting as someone they may be related to.

Mr JACQUES - It is really hard with no equipment, as a clinician. I have treated people on the ramp before to try to help out. I do minor things but you haven't got any of your equipment. You are in big trouble if anything goes wrong because you know that resuscitation bay is full. It is going to take a few minutes to clear that bay to get someone in, what do you do in the meantime and when there is nothing around?

Mr BRADLEY - It is an OH&S issue. Our corridors would be much wider if we didn't have beds in them but that is where we are at. The argument is there that we shouldn't stop with the K Block building in Hobart and we should be looking at a larger emergency department. I don't mean we need the biggest in the world, but we only have 27 lay-down spaces to see people.

Ms FORREST - If you did what you suggested - having a separate mental health emergency department and potentially a separate children's entrance and department - would the rest of it be reasonably adequate?

Mr BRADLEY - We still need to expand in certain areas. We need more resuscitation bays to cope with the increased population. We don't have enough parking spaces for ambulances because we have increased the number of ambulances on the road. They only have one place to go to because the private hospitals are usually on bypass so they come to us. There is this surge mentality with ambulance and they all seem to turn up at once. We don't have enough parking for

them. You see them park up the hill or they are coming down and parking and unloading and then doing a lap and finding a park outside the private hospital.

CHAIR - With respect to processes and procedures, day-to-day management in the emergency area, do you feel emergency nurse practitioners are getting enough input into solving the problems and issues in terms of place and flow and like or is this something that needs improving.

Mr BRADLEY - Talking from the south, we are probably change-fatigued because we have gone through a lot of change within our emergency department.

CHAIR - Is this because of the redevelopment or in general terms?

Mr BRADLEY - We have also done local redevelopment to try to increase our capacity. We got rid of our seminar room and turned that into a patient care area, which is our mountain area where the walking ill can be seen.

We are giving up space. We are probably change-fatigued. We have done that. We have done geographical team-based care and we have had lots of people come and tell us how to do patient flows. We have introduced PEN nurses; we have introduced navigators. We have the [inaudible] role and we have introduced nurse practitioners. We have done the whole lot.

CHAIR - Sorry, PEN nurses?

Mr BRADLEY - Psychiatric emergency nurses. They are valuable members of our team. We have done a lot to change. We need to now go to the next level and say what is the next bit to change?

My greatest worry would be is when we do build K Block, we have probably a six-month grace period with K Block and we will have reasonably good patient flow. We have experienced this with the rehab beds. Over time, it comes back.

CHAIR - In general terms across the state, the way things operate, are you getting enough input to the organisational side with patient flow and the like? Or are medical officers not consulting down?

Mr BRADLEY - Nursing staff get a voice, yes.

Mr JACQUES - Some of the membership have said to me they feel it is medically sided and a less medical fraternity profession approve it and then nothing happens.

As a nursing profession, if we looked at innovation and it was not seen as good innovation from another standpoint, it would not go ahead essentially. There is no clear innovation from one profession. It has to be across all. Allied Health included.

CHAIR - A holistic approach? You say this is not happening 100 per cent?

Mr JACQUES - It depends on different areas. I have worked all across the state and in different hospitals. It certainly works differently.

In Hobart there is a lot more integration of the professions, maybe with the nurse practitioner models and that short of thing, where we see we can all work together as one and a team, rather than as individual professions.

CHAIR - Is this since the THS has been restructured?

Mr JACQUES - No, I do not think that has made any difference -

CHAIR - Is that making any difference?

Mr JACQUES - I would not say so.

Mr BRADLEY - We probably have clearer reporting lines now. The structure was in a bit of a mess for a while but is coming back under control now, which is great.

Ms FORREST - In your submission, you talk about the Tasmanian role delineation framework and the Tasmanian clinical services profile. You talk about the current mismatch in resources, expectations, level of service delivery and the increased amount at single service hospitals and no capacity in workforce for infrastructure to support this - for example, maternity services in north-west Tasmania. Can you talk more about this? A couple of questions I have follow on from that.

Mr JACQUES - I think that is coming from the maternity services on the north-west; they were busy at Mersey with a lot of patient presentations, then overnight they essentially went to North West.

Ms FORREST - Are you talking about antenatal presentations?

Mr JACQUES - Both. Initially it was seen that maternity services would move directly to the Burnie site rather than be co-shared and there would be an antenatal service at the Mersey. I am not 100 per cent on all of the detail there, but essentially a lot of midwifery staff came down and worked in the emergency department and offered information about that.

Certainly, they were worried about their jobs and whether there was going to be a midwifery service at the Mersey and all such. What was the last part of that question, sorry?

Ms FORREST - I was trying to flesh out more on what the issues are around the increased demand at single service hospitals. It is under your heading dealing with factors impacting on the capacity to meet the current project demands. Are you suggesting because all the birthing is in Burnie, the private hospital not the public is an issue? Is it impacting on the patient outcomes but also the flow?

Mr JACQUES - I think I know where that comes from. Essentially emergency staffs were doing a lot of training at the time and I was an educator in the North West. To receive potentially birthing mothers in the emergency department is definitely not our specialty, but something we train for in the unlikely event it happens. Working in tertiary centres, I have not seen many births. One in 14 years, but at the Mersey I saw about 10. It is definitely different.

Ms FORREST - In the ED?

Mr JACQUES - Yes, within the emergency department. Not me personally working with them but I knew of them. It changed for us overnight and was challenging. Some of the membership were concerned that once all these specialties leave hospital, there would not be the mechanisms to achieve that elsewhere. Birthing mothers at the Mersey would wait until the last minute, would realise they were imminent, come to the Mersey and either give birth and/or we had to transfer them directly to Burnie at the time, and that posed a risk. Likewise high-risk mothers were asked to come either to Hobart or to Launceston, and they do not want to do that. You talk to the people and they say they do not want to do that – 'I want to have my baby here'.

Ms FORREST - Which is interesting in many respects when you think about the welfare for the child.

Mr JACQUES - Yes, and that posed a lot of concern for emergency because it was, 'They are going to come here: how do we manage this?'

Ms FORREST - In terms of when decisions are made, changes are proposed, I am not saying there was not consultation around that - there was - but some people did not get the outcomes they were seeking. That is one of the outcomes. You talked about the Princess Alexandra Hospital in Queensland being a magnet hospital and how that worked. In terms of the decision-making at the grassroots level when there are issues with patient flow or there are single hospital constraints like we described, where do you think the best solutions are? Even with the new structure, it still seems to be a top-down decision-making approach. Is there a way you see solutions can be found and delivered and promoted from the grassroots up?

Mr BRADLEY - At lot of the solutions come from grassroots staff so I see this would be a good way to go. I see signs of it in the Royal, which is great.

Ms FORREST - Under the new structure or just generally?

Mr BRADLEY - Yes, from my personal experience I feel as though I can take ideas upwards now and they get acted on or they get thought about rather than being told what we are going to do. Certain decisions need to be made at an executive level. There are certain decisions that need to be made at a higher level, but I think nurses on the floor can make some decisions to try to improve flow through the hospital.

Ms FORREST - Is there a place for the lean process used in a lot of manufacturing in health? This approach - whether it be a medical ward, a surgical ward or the DEM or anywhere - because it creates coalface suggestions, recommendations and a process to ensure they are considered. Whether they are acted on is another matter, but they are at least considered and going through a process. Is there room for this sort of approach?

Mr BRADLEY - There is room. I feel they could certainly come up with some way to work in ways of patient flow that would improve flow throughout the hospitals. This would come from using a lean methodology or any other methodologies you want to look at that would help. That would come from grassroots, and they should be empowered to make these plans and address some of the issues around patient flow.

CHAIR - Get a more holistic outcome, a better outcome?

Mr BRADLEY - That is right. It is a hospital's emergency department. The emergency department is not an island within a hospital. It is our emergency department, it is the community's emergency department, and we as a hospital should take the approach of looking at it as a community facility, and we should be serving the community well.

CHAIR - It is a major way of people getting into the hospital, then populating those beds.

Mr FINCH - I am comforted by your responses to recent questioning in respect of your ability to have your voice heard within the system. I appreciated your submission to the inquiry but I note particularly your graph shows the expected increase. It has not been diminishing at all. It has not plateaued at all and it is not getting better - it is getting worse. There is more need for you to have your voice heard in respect of the increasing workload and pressure you are feeling now. It is not going to go away in the future.

Mr BRADLEY - That is a conservative approach, the 1.3 per cent per annum; certainly in the south seeing 3 to 4 per cent with a little decrease at the moment because we are not getting the increased presentations that we would expect through winter but we are still on the same spot.

CHAIR - Yet it is less per capita in the south, or it was.

Mr BRADLEY - For beds? We had about a 60:40 split. I think there 60 per cent of beds are in north across the three hospitals and they have 40 per cent of the population and we have 60 per cent of the population. I do not know if those are the exact numbers.

CHAIR - I was referring to the attachment that specifically went to the numbers. I would have to quickly find that. It is on page 9, Appendix 1 where it talks about statewide presentations increased by 3.4 per cent. You go on to say a decrease of 3.9 per cent in the north-west per capita presentations was consistently lowest in the south, which is interesting, but that was back in 2013-14. It has changed significantly since then.

Mr BRADLEY - Yes, if you go into all the numbers we have, it certainly has increased. We see 63 000 and the department is built for 30 000.

CHAIR - Okay, that is a significant figure.

Mr JACQUES - We are certainly never going to be out of work.

CHAIR - Not today at least. Maybe as the baby boomer generation moves through it might change, who knows, in terms of the people presenting. Tony and Michael, thank you very much for presenting to us today. It has been a fascinating hour for us to look at these things. I remind you that things said here are protected by parliamentary privilege but they may not be when you walk out that door if someone wants to question you.

Mr BRADLEY - Thank you.

Mr JACQUES - Thank you.

THE WITNESSES WITHDREW.

PUBLIC

Dr EVE MERFIELD, RURAL DOCTORS ASSOCIAITON OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - This is the Government Administration A Subcommittee Inquiry into acute Health Services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege and I remind you that any comments you make outside the hearing may not be afforded that same protection. There is a copy of the information for witnesses available and I believe you have had the opportunity to look at that and you are well aware of that.

The evidence you present is being recorded. The *Hansard* version will be published on the committee website when it becomes available and you can look at that. The hearing is also being broadcast.

The opportunity here today is for you to make an opening statement if you wish to and that will be followed by questions from the members.

Dr MERFIELD - I am here as president of the Rural Doctors Association of Tasmania. What we wanted to bring to light is that we are looking at acute health services. There tends to be a focus on the three major hospitals in Tasmania. However, there are dedicated and skilled rural doctors and nurses working in teams in health facilities all over the state from Queenstown to St Helens, Smithton to Dover, providing acute health services.

These are somewhat under-utilised. They are a resource that is often ignored and not included in this area. But with some potential improvements and resourcing, those resources could be used as part of the solution for some of the issues currently going on in the acute health sector. The things we are talking about are the improvement or the setting up of the rural generalist training pathway in Tasmania. I am not sure how familiar you are with the concept of rural generalism, and I can expand on that if that is something that is necessary.

CHAIR - Please do for the record; it would be great.

Dr MERFIELD - A rural generalist is a doctor working in a rural context with an expanded skill set such that they work in primary care as well as inpatient services and have an advanced skill in a particular area. They work in groups such that those skills meet the demands of their local community. Traditionally this has been well set up in Queensland and some other states, and in those states it tends to be a focus on the procedural skills, such as GP obstetricians, anaesthetists, surgeons et cetera.

In Tasmania it may be the community needs in rural areas are more towards having people with advanced skills in mental health, palliative care, aged care, addiction medicine and pain management, and those advanced skills may be more appropriate. That is something communities look at on a local basis.

The rural generalist pathway is something that is being set up nationally. There is a national rural health commissioner, Professor Paul Worley, who has visited Tasmania on a number of occasions to try to get this happening here. Initially there was some state funding and a director of Rural Pathways was appointed. That state funding has run out.

Ms FORREST - When was that funding?

Dr MERFIELD - I think it was about three years ago but do not hold me to that; I would have to check.

A director of Rural Pathways was appointed and is still in a position but funding is becoming an issue as the state funding has run out and they are looking for funding from other sources. Mr Ferguson has stated his support for rural generalism but we need a bit more than verbal support.

The other issue is the rural medical practitioner agreement which rural doctors, such as myself, work under. It is a somewhat archaic contract now and the review process has just started; the first meeting was in Campbell Town about three or four weeks ago. That needs to be completely revamped so there is an industrial framework for rural generalists, assuming we can get more of them in Tasmania, as well as rural doctors working in a range of facilities from small multipurpose centres right through to the Mersey Hospital, potentially. I can talk about that a little bit further. The idea of that is we want to not just attract but, more importantly, retain doctors in rural areas.

The Mersey, in terms of rural generalism: I have brought a couple of copies of a paper that the Rural Doctors' Association, both nationally and the Tasmanian one, have formulated. It is available on the RDAT website.

CHAIR - We will hand this to the secretary. It is a tabled document.

Dr MERFIELD - That looks at how rural generalists can assist in a workforce solution for the Mersey Hospital. In that context, a rural generalist can be working in primary care as well as working in a number of roles in the hospital. As I said, the idea is that they work in teams with different specialties. All rural generalists have emergency medicine skills. That is part of rural generalist training, so that they can work in different areas of the hospital. If it is busy in emergency, they can go and help in emergency on top of the rostered staff. If it is not so busy, they can go and work in another area. The idea is that it is important to have quality care and they would be working in teams, perhaps with visiting specialists from the north-west region or elsewhere, who would maintain ongoing education, training, quality assurance activities and so on to make sure quality care is maintained.

Ms FORREST - What is the specialty area at the Mersey? Is it gynaecology or obstetrics and gynaecology? What is it you identify with at the Mersey?

Dr MERFIELD - What we looked at there, and in that paper particularly, were areas where locums are currently used. Locums are very high cost. There are issues with lack of continuity of care and some of the extreme costs, which would be decreased by having rural generalists. The sort of areas you would be looking at include the emergency department, as well as having GP anaesthetists who could assist the visiting surgeons with their lists. If you have rural generalist anaesthetists in the hospital who can potentially go to the emergency department if there is someone with an acute airway problem that requires assistance, it has that added benefit as well. You can have GP obstetricians, GP surgeons, GP Paediatricians and physicians to look after the inpatient care in teams with specialists

Ms FORREST - There is no paediatric ward at the Mersey any more, is there?

Dr MERFIELD - No, but it could be set up in that area if that was seen as a need.

CHAIR - Would it be the Mersey, or are you talking about the more regional hospitals?

Dr MERFIELD - That was talking about the Mersey. In regional hospitals, those rural communities have more need for things like mental health, palliative care, aged care and so on. We would probably be looking at more of those types of specialties in that area.

CHAIR - Lots of things can happen after hours. Are you saying the rural medical officers would be prepared to do those hours?

Dr MERFIELD - They do now in St Helens, Queenstown, Smithton, Oatlands and all the other rural centres where there is 24-hour emergency cover, so that is happening. It is often difficult to staff because of that. That is where the Rural Medical Practitioners (Public Sector) Agreement review needs to make those more attractive, to retain people and have adequate staffing to maintain that 24-hour cover.

Ms FORREST - I can't remember the exact number of GP obstetricians in Smithton when they were birthing down there, and Queenstown.

Dr MERFIELD - There have been GP obstetricians in a variety of places around the state but most of them have now gone because of the issues. That is not necessarily a primary thing but it could be something that might be of help in the Mersey where birthing services may be able to be reinstated.

CHAIR - Can you give us a bit of an understanding as to how much dialogue has happened between the Rural Doctors Association and say, the minister, in terms of introducing things like this.

Dr MERFIELD - There has been a fair bit of dialogue. As I said, a director of Rural Pathways, Dr Allison Turnock, has done a lot of work particularly in the area of rural generalist training. I believe she has fairly regular contact with the minister's office. RDAT - we have three monthly meetings with THS and a fellow from the minister's office whose name I have temporarily forgotten, but we have regular meetings. Mr Ferguson attended both rural medicine conferences last year, and the year before we had the inaugural rural medicine conference in Tasmania. He attended both of those, and Professor Paul Worley was at the one last year talking about rural generalism. He is aware of rural generalism and what it means and hopefully what it can do for Tasmania.

CHAIR - Have there been any commitments at all made in terms of moving it forward?

Dr MERFIELD - As I said, the director of Rural Pathways has been working on trying to set up a rural generalist training pathway because there is quite a bit involved in it. It would take three to five years for the first ones to start getting turned out because they have to be adequately trained. We are talking about the right doctor with the right skills in the right place. You cannot just have anybody doing it. It does take a bit to set up. We have secured some training places and there are currently four junior doctors who have embarked on rural generalist training, but at the moment there is not a set end point because the industrial agreements for how a rural generalist will be employed are not in place yet. They have started but they do not know what their end point is terms of where they are going to be in full employment.

Mr FINCH - I am curious, Eve, in respect of the numbers of rural generalists who might be available in Tasmania, for instance. Have you some idea of how many would be able to fulfil that role? Also, too, extrapolating that, where they could go, given these recommendations and the desires of your organisation?

Dr MERFIELD - There are many rural doctors working in that role even though it is not necessarily recognised, as rural generalists around the state already are dealing with emergencies, having inpatients and doing a lot of the work there. I do not have a figure or numbers exactly that would be required.

Mr FINCH - Ten, five?

Dr MERFIELD - No, it would be a lot more than that. You have, I think, probably over 15 rural medical centres, and to provide 24-hour cover in those you are going to need at least four or five doctors in each place.

CHAIR - You are talking about places like Campbell Town and St Helens and those sorts of places?

Dr MERFIELD - Yes. Oatlands, St Helens, Scottsdale, Smithton and Queenstown. They are all there already; there are doctors already working in them. They are just not recognised as rural generalists as such. A lot of them have rural generalist qualifications, myself included, but we are not recognised in this state for that.

Mr FINCH - Where do you get that qualification from?

Dr MERFIELD - The College of Rural and Remote Medicine has a particular rural generalist qualification. The College of General Practitioners has a rural component to its training. You can do extra training to become rurally trained. Both general practice colleges but particular ACRRM is very specialised in that area. They have done a lot in Queensland and they originated in Queensland.

Mr FINCH - Do you have a sense that this role or the job that could be done by rural generalists is undervalued or not recognised?

Dr MERFIELD - I think probably that is the case in Tasmania. As I say, other states such as Queensland have rural generalists running rural hospitals throughout the state. It is well recognised and they have a remuneration package and an industrial agreement that covers it and recognises their skills.

Ms FORREST - A state-based one?

Dr MERFIELD - Yes.

CHAIR - They have some very isolated areas, no doubt. It would benefit the whole system, I guess.

Ms FORREST - On that, one of the things we hear and, as you said, the focus is on the three major hospitals and that always seems to be the case. That is where most of the money goes. Bed

block is a major issue, and we hear from people who have talked about that it is predominantly medical patients where the bed block exists.

In terms of rural generalists looking after some of these smaller regional hospitals, and we know from the figures that there are always beds in them, some of the occupancy rates are down 25 to 30 per cent and that could be part of the solution. Some patients do not want to move to a regional hospital. In terms of making it work for everybody, do you think we need to put this more in the mix and have rural generalists looking after these patients and then seeing them through to discharge?

Dr MERFIELD - Exactly and that does happen. Last week, we only had two beds in Dover we can use and we had two chronic lung disease patients with chest infections in those beds. They did not present to the Royal Hobart Hospital as they might otherwise have done where you can manage them. We know their families; we know their services available when they go home and they need a bit of oxygen, some medications which we can do quite well and the facility can be used.

It also can be used as a step-down facility for patients post-surgery. Sometimes we are told Royal Hobart Hospital is going to push them all out and we will send them to wherever there is a bed. That does not work because when we have had them ring and say, 'We have a patient from New Norfolk and we want to send them to Dover.' Well, it does not work because all the benefits of being in Dover are when you come from Dover and if you send a patient from New Norfolk, we do not know what services are available. We do not know them or their family or how they manage at home normally, so it does have to be done appropriately.

I have sent patients to the hospital with a letter saying, 'Could you do some investigations which we do not have access in Dover? We are happy to have them back as soon as we can manage them', and we never hear of them again.

Ms FORREST - It is unutilised?

Dr MERFIELD - Yes.

Ms FORREST - That is from the medical and surgical step-down?

Dr MERFIELD - Yes. The discharge planners are often aware of it but when they change, it sometimes gets lost. The other issue is the rural medical practitioner agreement is such that whether I have no patients or my beds are all full, I get paid the same.

Ms FORREST - You are better to have them full.

Dr MERFIELD - We try to keep them full.

CHAIR - It is not very efficient if the beds are not full.

Dr MERFIELD - No, that is right and we certainly try to keep them full. At the same time I am running a busy full general practice. We are seeing the patients before work, after work and in between.

CHAIR - The general practice is actually at the rural hospital location?

Dr MERFIELD - In Dover it is, but not always the case.

Mr FINCH - You have referred to locum services having to come into Tasmania to support the medial services in the state. You recognise there could be a quite a substantial number of savings made if we went more to rural generalists?

Dr MERFIELD - Where we are looking at the Mersey hospital, we have actually given you a cost analysis of locums versus rural generalists and you will see it is a fairly significant saving in that basis. The loss of continuity of care is another big issue when you have locums who come and go. They might be there for a couple of weeks and then they are gone whereas with a stable workforce, it is much improved. There is also the issue around ongoing education and training, locums do not tend to be involved with education and training of junior doctors. Your next generation of doctors, if they are exposed to rural generalism and can see that and get trained in that becomes self-perpetuating.

Mr FINCH - What sense do you have of the future for the Rural Doctors Association in Tasmania? Do you feel there is recognition and you will be able to cut through with your arguments and maybe get more recognition from the minister and the department to see the progression of these ideas you have put forward?

Dr MERFIELD - I would like to think so, but I hope the national push with the appointment of the National Rural Health Commissioner, Paul Worley, will also produce some pressure from the other side, so we can approach it from both aspects.

Mr FINCH - You are feeling positive in respect with pushing through with this idea?

Dr MERFIELD - I would like to think so. It is a little disappointing the funding was not continued for the Director of Rural Pathways. The area should be looked at because she was doing a good job of finding junior doctors interested and trying to get them into training positions. There is nobody who is funded to do that if we lose her position. We can try to do it in our spare time but, as a rural doctor, there is not a great deal of that.

Mr FINCH - Was that state funding?

Dr MERFIELD - That was state funding, initially.

Mr FINCH - How long since that has been diminished?

Dr MERFIELD - I believe they were given some funding approximately three years ago. Don't hold me to that but I think it was about that. They managed to stretch it out pretty well because they were pretty good on their budgeting. They stretched it out for longer than they thought it would initially last. It has pretty much gone now.

Mr FINCH - Would there be a push to re-establish that funding?

Dr MERFIELD - They have asked for additional funding but it hasn't been forthcoming as yet, I believe.

Ms FORREST - That is state funding?

Dr MERFIELD - Yes, state funding.

Ms FORREST - Going back to the Mersey again because you have the workforce plan for that. One of the reasons given for removing all birthing from the Mersey and taking it to the private hospital in Burnie where the contract exists was the safety of women and babies. When we have had rural GP obstetricians on the west coast and in Smithton, there were claims it may not have been as safe as it needed to be for women and babies. I would love to see birthing reinstated at the Mersey. I think you would have to restrict it to low-risk women. Is that the argument will continue to be put? Often it is the anaesthetists who get a bit anxious about this.

Dr MERFIELD - Yes, if you have good GP obstetricians, it works very well in multiple hospitals in other states with adequate safety mechanisms in place in order for it to be a safe place for women to give birth. The Mersey is a reasonable-sized hospital, and if you have GP anaesthetists and so on within the hospital as well, or anaesthetic services -

Ms FORREST - You would need GP anaesthetists to make that work, do you think?

Dr MERFIELD - Certainly, in other places there tends to be a team approach and that is what we look at. You have a team with a GP obstetrician, a GP anaesthetist and so on in places such as Queensland. You have to look at what safety mechanisms need to be in place. I am not an obstetrician so it is not my area of expertise.

Ms FORREST - Would you also need a GP paediatrician?

Dr MERFIELD - I wouldn't have thought so, for a baby who is born. Rural centres should be trained in neonatal resuscitation as part of their training for the emergencies anyway, so I don't see that as a big issue.

CHAIR - Is there anything else you wish to inform us of before we finish?

Dr MERFIELD - There was one other thing I wanted to raise if I am able to in the time.

CHAIR - Absolutely.

Dr MERFIELD - One other thing that would greatly assist rural centres is better telehealth. When I worked in New South Wales 15 years ago, the rural centres had a direct link to the emergency department of their closest hospital – for example, a camera in the emergency room of the rural centre. This meant that the emergency physicians could see the patient, which can be very helpful rather than just talking on the phone, could see the monitor and the ECGs, and could give advice. Sometimes this meant that patients could be kept in that centre and not transferred. If they said they did need to be transferred, but asked us to do this, this and this before they left, it would decrease the length of time they needed to stay in the hospital. It also had other benefits within the integrated teams of mental pain management, palliative or whatever - those specialist consultations can occur within a telehealth context so they could be seen and heard. You get a much better consultation that way.

I think telehealth in Tasmania is a long way behind other places and is something that would vastly improve services, not only that but also for outpatient appointments. Our patients travel all the way to Hobart. Elderly patients have to try to find a parking space, with the trauma associated

with going to the Argyle Street carpark and so on for a five-minute appointment, then they have to drive home again.

CHAIR - Yes, or sometimes to arrive and the person they came to see is not there.

Dr MERFIELD - Yes, and they have to come back next week – 'Well, I have just driven a four-hour round trip to get here.' Telehealth could be much better utilised.

CHAIR - It is interesting because there were trials here in the early stages of telehealth. That was going to be an advantage for places such as Flinders Island and King Island and the more isolated areas of the west coast.

Dr MERFIELD - Parts of the east coast can be of some distance, too. St Helens has a lot of emergencies.

CHAIR - That would seem to be of benefit. Thank you for putting that on the record. We will see how that goes. Thank you for coming and presenting to us, Dr MERFIELD. It is appreciated. Again, to reiterate, everything you have said is covered by parliamentary privilege but it may not be if you say anything to the media outside if they chose to interview you. It is very much appreciated and every bit helps in terms of trying to build the picture we are reporting on.

Dr MERFIELD - Yes. We, as rural doctors, want to be part of the solution.

CHAIR - Thank you.

Dr MERFIELD - Thank you.

THE WITNESS WITHDREW.