The committee recommenced at 10.30 a.m.

CHAIR - Before we start, you were given some information by the secretary of the committee, and I will ask whether you have read the information that was sent, and I want to reiterate some important points. This is a committee hearing that is a proceeding of parliament, and that means it gets the protection of parliamentary privilege. That is a legal protection that means you can give evidence to this comittee with complete freedom without fear of being sued or questioned in any court or place outside of parliament. It is so that we can get the best possible information that we need to be able to conduct this inquiry.

It is important that you understand that protection does not follow you out that door, and that if you make any statements outside that could be defamatory, even if they are words that you had spoken here in the committee, you are not covered by parliamentary privilege when you do that. This is a public hearing, so there are people from the public and journalists who are present, and your evidence might be reported. It is important that you let me know if you want any part of your evidence to be heard in private. We can go in camera to do that at the end or at a time when you want to do that. Do you understand?

Mr PITTAWAY - I do.

Mr DAVID PITTAWAY, ED NURSE MANAGER, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - David, you have had a long career as a nurse, from my figures something like 38 years. For the last 13 years you have been working at the Royal Hobart Hospital, and for the last four years in a very senior position as the associate nurse unit manager in the emergency department. Thank you for your information-rich and very clear, easy-to-understand submission. We have read it and there is a lot of detail here.

We are going to go through and ask questions about it. I wanted to start off by asking you to tell us what it used to be like when you started working at the hospital, and how you have seen things change - if you have seen things change - in the time that you have been working there.

Mr PITTAWAY - Certainly. I would like to start out by clearly stating that the emergency department is not the problem when it comes to ramping. Ambulance Tasmania is not the problem when it comes to ramping. In my opinion, the problem -

CHAIR - If you have a statement you want to make, you can do that now.

Mr PITTAWAY - I was just saying it as an opening statement.

CHAIR - I should have asked you.

Mr PITTAWAY - What I believe the Government and the parliament in its entirety and the State Service need to accept is that Tasmania does not currently have the tertiary hospital bed capacity the Tasmanian population needs. Please start addressing this basic problem as a priority. Thank you for that opportunity.

To your question, I have been at the emergency department for 13 years. I started there with no effective critical care experience for the previous 20 years. When I first started at the Royal in the emergency department, it was not an unusual event to have absolutely no patients in the emergency department. That must have happened five or six times in my first couple of years. In that time there has been a gradual increase in the acuity of patients, but more importantly, in the complexity of patient conditions which has bought them to the Royal.

Subsequent to that, more and more ramping events. If I go back first, probably really made an impact on a department in 2015, about eight years ago I would say. Since then, it has been more of a problem especially for the emergency department it has been a problem because we are the last, we cannot close our doors. Other wards can close their doors, residential aged care facilities can close their doors. All sorts of assisted accommodation providers can close their doors. The emergency department does not.

This has had a major impact, especially on staff, staffing, staff recruitment and staff retention. I emphasise the point of skilled staff retention. Fully staffed does not mean fully skilled and that is one of the big dangers facing - and I expect it is all emergency departments. I can only speak for the Royal Hobart Hospital but it would not surprise me if everything I have to say equally applies to the Launceston General Hospital and to the North West Regional.

CHAIR - Is it correct to say that there has been an increase in pressure with the ramping situation that has occurred and all the focus being on the emergency department? How has that flowed on to staff, to you and to other people who you work with?

Mr PITTAWAY - I am one of probably four or five staff who remain since when I first started. A concerning number of staff have left in that time, since that eight - year period I mentioned. The comments are, this is unsafe. I do not want to front the Coroners Court. That is a very common concern of people who have left the department. I have heard, anecdotally comments like, 'I can go and work elsewhere for better money and I do not have this stress'.

Having so many people in the waiting room who should be in beds because of their clinical or physical presentation and the staff who are, as I have mentioned in my submission, the clinical initiatives nurse, the CIN. Many of the staff in this role come to the navigator or the clinical coordinator, we are both the associate nurse unit manager (ANUM) roles expressing their concern and their dislike for the role that puts them under pressure being in that role.

People who have been in charge previously, prior to the implementation of the navigator role and ANUMs, they would leave the hospital because they could find what they considered to be less stressful, less dangerous and less taxing work in many other fields. They have gone to private hospitals and some have left nursing totally, they have just had enough because they feel nothing has been done to satisfactorily address the issues that they are concerned about. They have felt it is best for them to leave the Royal Hobart Hospital, which is a tragedy for the people of southern Tasmania.

CHAIR - The safety and the dangers that you are talking about, what do you mean when you say those things?

Mr PITTAWAY - There is two sides of safety and danger. One is professional safety and danger for the staff, the other is physical danger and medical danger to the patients. I believe our triage nurses do a very good job. They have been appropriately triaged to either

the waiting room or to be ramped in the takeover of care area. One of the problems safety wise there is that if the department has no beds to accept people from that ramping area, most often times they are seen by a doctor when they are in an ambulance ramping area. The ambulance crews, quite rightly, do not allow a lot of the treatments and investigations that we would like to commence on patients because it's not within their scope of practice. With most of them I have no problem at all that they could deal with the treatments and managements that the doctors would want them to have, but the ambulance crews would be putting themselves in a professionally dangerous position.

Then you have staffing concerns, especially when you've got patients in the waiting room who might need antibiotics, or it might be desirable that they have transfusions or they present with what could be potentially urgent problems that need addressing, but they're not under constant observation. In times of ramping, the priority is to get patients from the ramping areas into the department, and therefore patients in the waiting room may not be able to be assessed as clearly and succinctly as you would like. They do get left. That's where we've had people collapse. Having people collapse in the waiting room is not a rare event. Then it's a game of shuffling chairs; we've got to immediately concentrate on those people, all the time having pressure from upstairs saying you're supposed to be taking patients from the ambulance ramping area.

I quite happily will just ignore that when I believe that it is in the patient's best interest. That is what we're there for. We are all working at this emergency department for the patients, for the people who turn up for our urgent care. Sometimes it's not immediate care that is needed, but everyone who turns up to the emergency department is distressed to some degree or another. We need to be there to help these people.

When we tell them to go to the waiting room, then there is increased angst and anxiety among the people waiting, both the patients and their relatives, seeing ambulances coming in. The staff who have to deal with the patients in the waiting room, often have to bear the brunt of that angst and anxiety. Probably on 10 occasions, after an evening shift is finished when the staff has gone, I have apologised to a full waiting room. I've stood there and said on behalf of the ED, 'I apologise that you have to stay here'. I've said, 'Please don't take it out on our staff, there's nothing we can do here. We're going to do our best'. I got clapped once.

CHAIR - Good on you for the work that you do.

Mr PITTAWAY - That's what we face.

CHAIR - I'm alarmed to read that the clinical initiative nurses you talked about are sometimes charged with caring for more than 10 patients at a time and that there are other patients who haven't been given a bed in ED, including ramped patients. They can be wandering round all over the place. How frequently do these sorts of situations occur?

Mr PITTAWAY - Anecdotally I was told that in the last four weeks maybe 50 long-term patients were discharged to residential aged care or other similar facilities. That was not their preference. To be blunt about it, they were basically kicked out because their beds were needed but, as I understand it, they were not going to their location of preference, which must be distressing for them and their families.

Having said that, it did free up a lot of beds, which tells you that the ED is not the problem. The problem is congestion in the hospital. The complete health service is not able to keep the hospital following through. There is a blockage of people leaving the hospital. So, it has not happened as much, but previously this was a daily event, especially in the evenings.

One of the triage staff came to me and said you never come to the ED before 5 p.m. because you won't get a park. So, people are turning up after 5 p.m. because they can get a park close to the hospital and then the waiting room fills up. It is nothing to have 15 or 20 people in the waiting room when the hospital is at escalation level four, which used to be front page news - but now it happens every day and no one cares about that. I have never heard of a tier one response being front page news, but that is happening disturbingly regularly. When you have that sort of event happening regularly, we have now increased staffing to have two clinical initiative nurses - one for the waiting room and one for the take-over-of-care area.

CHAIR - So, they are not being split like they were? They were split between those two areas, but now -

Mr PITTAWAY - That is if we have two. We can have one for the waiting room and one for the take-over-of-care area, which is 50 to 75 metres away.

CHAIR - And that occurs now, you said?

Mr PITTAWAY - Yes.

CHAIR - Okay.

Mr PITTAWAY - But that is only if we have the staffing.

CHAIR - Okay.

Mr PITTAWAY - Fully staffed is not fully skilled. There is not a problem getting the numbers of staff. That is happening, but they are not skilled for the Royal Hobart Emergency Department. They cannot walk into re-sus and just start working with the already experienced staff. There is a real lag time for these people to learn. Even then, a lot of people say, 'Why would I want to work here? I can work elsewhere for less stress, more money and somewhere where it does not cost as much to rent'.

Ms DOW - Thanks so much, David, for coming in and presenting to us. It is great to have you with us and to have your first-hand experience. Could you elaborate and expand on having staff and being appropriately skilled. You've provided a couple of examples. Are there other examples that you could provide to the committee of where you do have the people on the ground but they just do not have the experience or expertise that is required in the emergency department?

Mr PITTAWAY - As a general rule, it takes two years for a competent starting-off nurse with no real emergency department skills to progress through to the triage-skill level. Once you have progressed through to triage-skill level, that means you are also deemed competent to work in the resuscitation area at a level of what we call procedure and airway. Airway is assisting in intubations and also operating our ventilator machines.

In times of ramping, it has been not unusual for ICU and HDU units not to be able to take intubated patients, so we must have skilled staff who knows how to use a ventilator, not to mention all the medications required to maintain a person safely while they are being ventilated.

We need that staff member to look after that person, who then has to stay one on one with that person. We are the trauma centre for the state so that is one person who is not available to deal with another trauma case or someone who has life-threatening sepsis or similar who also needs advanced knowledge of airway skills. We need six experienced resuscitation nursing staff on any one shift plus, ideally, the clinical initiative nurse who should have something of that experience too. They are dealing with more clinically unwell and more needy people in the waiting rooms and their judgment is essential.

When I am in charge, I talk to the CIN who's in the waiting room and ask whether anyone there needs a bed. I say, 'You've got to keep your eyes on them; walk around there'. That scares a lot of staff but we talk them through it. If there is one thing that I'm proud about being at the Royal is that it is a very cooperative and collaborative department. It wouldn't be there, if we weren't.

I'm going to be needing that place soon and I'm going to make sure they can look after me properly.

Ms DOW - The only other question I have is, in your submission to us, you talked about some further actions that could be taken by the state Government in the short, medium and long term. One of the things was around more cleaning teams. During our tour of the Launceston General Hospital yesterday, we learnt more about the need for the cleaning of beds and the process and the time that that takes. I would appreciate your thoughts on that and why you included that in your submission. You said that you have psychiatric patients regularly admitted for long periods of time - up to two or three days in the ED. What impact has the closure of St Helens Private Hospital in Hobart on an already strained system when it comes to psychiatric patients for your team at the Royal Hobart Hospital?

Mr PITTAWAY - I don't know that I could comment that the closure of St Helens has made a huge difference to the Royal. I haven't seen a lot of change in the flow of patients from the emergency department to the department of psychiatry. That is a real concern because, for one, it is just not the right place for these people to be. Again, they're stressed people who have any number of multiple conditions and circumstances. Quite often, their mental illness has been triggered by some sort of life event. They might be homeless and have issues with family, their animals or with money. Then they come to the emergency department stressed and then they're in a window-less, effectively airless area for days on end, yelling and screaming at people - quite reasonably - 'What are they doing there?'

I can't comment on what's going on upstairs. All I know is my little world is the emergency department. But they stay. I don't know what the answer is; that's for the people who have been running this show for however many years. Nothing's changed so I'll just leave that one hanging.

Why I have mentioned cleaning was that in going through the terms of reference, I set my presentation out as the cause of transfer of care delays or the cause of flow. I have thought of every response that has ever come to me from a nurse in charge saying, 'Why can't this

patient be transferred up?' That is why I have listed all those things. To me it is like: if you're waiting for cleaning, why aren't more cleaners available?

Consider when cleaning is done, especially with someone who is suspected of COVID or another nasty transmission-based infections, which I might remind people is the future of health.

Ms DOW - It is.

Mr PITTAWAY - There's going to need to be more of this stuff, not less. If someone says, 'We're waiting for a bed ', and I say - 'Okay, can you please give me a time frame?', it's not unusual to hear, 'half an hour to an hour', because every surface in that room needs to be cleaned. The walls and every fitting need to be cleaned, because you don't know what people are going to touch, so it makes sense. Obviously, we need more cleaning teams, don't we?

Ms DOW - Yes, I just wanted to understand whether you thought there was a shortage of cleaning teams across the Royal. Obviously you could do with more resources.

Mr PITTAWAY - Precisely. To me, if you are waiting, why are we waiting? Again, it all comes back. So the emergency department waits.

Mrs ALEXANDER - David, thank you very much for your submission. I have a couple of questions as well. Would it be fair to say that because the patient's acuity has changed so significantly over a number of years and the Government has failed to recognise and plan accordingly, we are in the situation we are at the moment?

Mr PITTAWAY - I would not necessarily say the Government. I would say parliaments generally and elected members generally, because this is not a partisan issue which is why I have made the call also to be thinking about health as a holistic issue and a bipartisan issue. That to me is an obvious solution - don't have, 'Oh we will do these four years, oh it's our turn we are going to stop that, we will do this for four years, oh it's our turn again, we will do this' - that is nonsensical.

Having said that, yes, I agree, I do concede that we have stopped people from dying from heart attacks and strokes and simple medication stuff. Now we are in a position where we have people with incredibly complex needs that they would have died from previously, but now with simple medication changes here and there, they do not die, which is great. I am not saying this is a bad thing, but it is not being recognised and now these people just need a little tweaking, maybe three to four days in hospital, get them back home, the GP can keep managing them.

Then there is an increasing number of these same people are at home alone. This is where the Commonwealth Government, I believe, needs to come in and assist in terms of that whole aged care business and residential age care facility packages and all that sort of thing.

Mrs ALEXANDER - David, just to clarify, my question was not political. When I am saying government, it is governments in general, basically.

Mr PITTAWAY - I wasn't suggesting you were.

Mrs ALEXANDER - Long-term strategy planning for how to improve that to respond to the patient acuity like you said, the increased co-morbidity, the increased number in elderly patients and the different type of presentations.

My next question is, would you say from your experience and observations that over the last few years the capacity to discharge the elderly patients and those patients on NDIS has become slower and slower, therefore retaining them in hospital longer?

Mr PITTAWAY - I cannot comment on what happens up on the wards. All I know is that they are full. That's what I get told, so you would have to ask staff members from up on the wards that.

Mr BEHRAKIS - I have a couple of short ones. Going back to the cleaning, you said some of those are more complex especially with COVID-19 could be as much as half an hour to clean a bed -

Mr PITTAWAY - That is the timeframe I am told will be until the bed is available. I'm not sure how long it takes.

Mr BEHRAKIS - That was going to sort of be my question. If it takes them x amount of time on average to clean a bed, how much of that on average would be the time it takes for the bed itself to be cleaned and how much of that is waiting for available cleaners to actually get there?

Mr PITTAWAY - You would have to ask the wards that.

Mr BEHRAKIS - Thank you. Going back to the aged care, you have your medium-term solutions to work with federal government departments to improve residential aged care facilities, especially the medical services available which is what I wanted to question on, that would obviously make it reduce a number of cases where people have to attend the emergency department if they are getting better at aged care services. Earlier you said there was an incidence where a bunch of people were moved out and sent to aged care services, perhaps not where they wanted to go, but it did actually make beds available -

Mr PITTAWAY - That is what I was told.

Mr BEHRAKIS - Would having better equipped aged care facilities also make it easier to move people from the ED, perhaps they could move back to an aged care facility where they are able to get a high level of care than they might be currently if that was done?

Mr PITTAWAY - I would like to think that the outcome would be similar. I was working in aged care for two and a half years before I came to the Royal. Having said that, it was a small facility down at Dover, there were only 16 residents there, so it was not a large facility. But I make that comment because we constantly have residents coming from aged care facilities and we must know why they have come here.

We are making assumptions, but we assume that when you have a patient who is unwell and sometimes families disregard the advanced care directive and say, 'No, we want everything done,' that happens. We then also have patients who are residents of aged care facilities who are disruptive and an educated guess is that the level of care and attention required for that

disruptive person to be dealt with at that facility means that there are a whole lot of tasks - and these are task-based places - that are not getting done for all the other residents, therefore it is a whole lot easier to just call an ambulance and have these people transferred to the Royal. Then the Royal and the Emergency Department have the problem of dealing with this aggressive, confused, and no doubt scared resident, who may be having a mental health episode or a health episode, that is just not getting addressed.

In short, I would like to think that would happen. With better medical facilities available, better staffing, and better training of staff. Not just the one RM, how about a couple of RMs. These are the elderly in our community, and they deserve that.

Ms O'BYRNE - Thank you very much for the submission. You sum up a lot of things that I think have been mentioned by experts in the space for a while, which is that it is not an ED problem, it is through put and a discharge problem. It is about how we transition people safely and about the amount of time people spend inappropriately in ED, inappropriately in ICU, inappropriately in a ward before they get home.

You talked about cleaning, and most hospitals run a 7-3 cleaning shift, with some access outside of that but limited. But between cleaning and the other allied health delays, how much of an issue is it that we run a 24-hour health system, but we run it on a Monday to Friday, 9 to 5 or 7 to 4 time frame in terms of all of those additional roles? Whether it be cleaning, whether it be a number of the allied health provisions. If we are investing in that space, so we could transition people faster or more cleanly through the system, what kind of difference do you think that would make?

Mr PITTAWAY - To individuals, especially the allied health situation, my first thought comes to social work. That is a big problem. Homelessness, domestic violence, adolescent mental health issues, especially when that impacts with family members. It would be good to have maybe more on-call people available, not necessarily in the hospital. When you talk about the allied health side of things. What we are having greater issues with is interpretive services. Having access and then also correct gender interpretive services. Males having to go through a female or females having to go through a male interpreter is not necessarily the culturally appropriate thing to be doing. That sort of thing would be helpful.

We work really well. The emergency department runs very well, has been forced to run very well. Tinkering around whatever is happening in the ED is not the issue. It is basically what is going on upstairs in terms of 'where flow out' of the hospital. I hear all sorts of anecdotes about why people are or are not being discharged. Having said that, at the moment we are having a disturbing number of re-presentations of someone who was discharged on a Friday and then we see them on the Saturday evening or the Sunday. Discharging on a Friday is bad news because as you have identified, health is not a 9 to 5 issue. People need to be able to link in with support services. Support services need to probably have their time extended out of the hospital.

On the other side of it, getting the private hospitals on board would influence it. We have private hospital liaison staff whose job is to go around and identify who can get to the private hospitals. Private hospitals tend to be run for office hours in my experience. That is what they are there for. They are not there to take people at 3 o'clock in the morning in an emergency. Quite often they do not have admitting physicians or surgeons so everyone has to come to the Royal Hobart Hospital.

Mr BEHRAKIS - A last question. On page 9 of your report you have mentioned HACSU's industrial actions. You mentioned that it has caused some consternation and frustration and even tension between crews. Can you expand on that a little bit?

Mr PITTAWAY - I fully support HACSU in what it is trying to achieve. As I say, Ambulance Tasmania is not the problem.

This particular issue, as I understand it, gobsmacks me: that a union can have an enterprise bargaining agreement signed off by a government that affects an entire hospital, yet no one from the hospital, other than the union, had any input into that agreement. Without significant changes to flow, in and out - because the other side of it is, as you previously mentioned, is that maybe we need to look at the inappropriate presentations to the hospital. There are not that many. If this 60-minute cut off for take-over-of-care happens, I can see very dire safety events happening. I can see industrial action possibly happening from other unions. I can see staff saying, 'No, I am not putting up with this'. This is a red flag. This is danger, danger, danger.

CHAIR - It is the flow-on impacts of that. It would solve a problem here but push into the ED.

Mr PITTAWAY - At the moment when we have a tier two response, for a lights and sirens transfer, the navigator in charge of the department, who is supposed to keep flow going and be the trouble shooter, is often there by myself, or by ourselves, and we are supposed to take a patient on a trolley in front of our desk. That is part of the protocol. Who knows what could be wrong with them but that is part of the protocol. That is what would be threatening to be implemented if this happens without subsequent resolution of the causes of ramping.

I back their position but some staff members are a bit more militant than others in how they want to enforce their work bans. They are quite right in what they are doing. I guess it is their steadfast refusal and how they have communicated their message is part of the problem. They could have done that a lot better. But yes, certainly it is so easy just to do something but it is out of their scope of practice.

Mr WOOD - Thank you, Chair, and thank you David for your time and your really detailed submissions. It is really appreciated. Would you care to elaborate a little further on returning hospitals to 80 per cent capacity? As a short-term solution how do you foresee that being implemented?

Mr PITTAWAY - I believe that is what used to happen. It was so there was some slack. It was so that we could deal with a surge of incoming from whatever. We have seen it over the years. Australia-wide, we have these disastrous events from whatever and all of a sudden all these people are unwell and injured people come to the hospital and need care.

I think the other thing that people forget is that that this is a teaching hospital. It is a teaching hospital for a reason and that is to pass on skills. It is to skill up doctors, nurses. It is to skill up orderlies, clerks, cleaners and speech pathologists. It's everybody. In the time when people are not busy, they can take that little bit extra time to show something to their colleagues but also, they can use that time to give appropriate and needed patient care. That is the other thing that I think so many people do not realise.

Back when I did my training way back last century, we were encouraged to spend time with patients. When you can spend time with a patient, and you can dig a bit deeper into their history or their reasons for being here or why they are just sitting there, just staring out the window, that is when you get holistic healthcare happening. At the moment, we are having production-line healthcare. That is probably the best way to say it.

We have a hospital that is at 100 per cent capacity and has no slack. From my position at the navigator's desk, I can see what is happening in the rest of the THS. I can see that, you know, Launceston is on level four and Burnie is on level three and Mersey is on level one or two or whatever. We can see that this is happening all around the state. To me, it is industrial healthcare. It's push in one end, push out the other end. If that is what people want their health system to be, so be it but you will not be having many staff staying.

CHAIR - David, could you talk about the relationship between understaffing and bed capacity. You talked a bit about it in your submission? The 80 per cent capacity, which would be ideal to achieve, is affected by the level of staffing and bed availability. There is a relationship between understaffing and bed availability. Is that correct?

Mr PITTAWAY - It is my understanding. I think what it comes to is that it is a bracket creep. As we have alluded to with the increasing complexity of patients via multiple comorbidities that people, and with the wonderful advances we are having in care with imaging and that sort of thing, we have a bracket creep of people who are sicker, need more interventions, are staying longer, but we have had no change in, for instance, the nurse-patient ratios. They have been static. Similarly, there has been little change in pay.

I have been thinking about this over the previous days and I think that's what it boils down to - people are staying longer with far more complex conditions. For instance, just an example, an older obese person who has difficultly with mobilisation, with diabetes and arthritis, and they're relatively immobile on a big bed. They need pressure care, they need regular hygiene, they might need help with their meals, they might need help with their medications. How many of these do you have on a ward? These sorts of people weren't patients 10 or 15 years ago; there's increasingly more of them now.

Also, people to an extent have become slightly more demanding of their health carers as well, and that's not such a bad thing. People are speaking up and being advocates for themselves and that was probably a bit of an issue previously. The number of people that come through in their 70s and 80s who just shut up and go, 'it's okay, I'll just suck this up'. They shouldn't be having to do that.

CHAIR - How would you describe the adequacy of staffing levels at the moment, maybe you can't comment?

Mr PITTAWAY - I can't comment, as I say. I was nightshift last weekend and a comment was one ward could not take an admitted patient because their staffing didn't allow it and they would have to stay until the morning shift. Similarly, there was a patient who required ICU-level care and ICU was full so that patient had to stay in our resuscitation bay, because they were too sick to go to the general area, they needed that one-on-one specialist care from the experienced resuscitation staff. That one person was in our resuscitation bay, that was a resuscitation bay that was unavailable and a staff member that was unavailable, because they

had to be with that person because of their condition. In terms of the actual staffing there, well again we're back down to, 'okay, I've got to try and support other people in that role who may not be comfortable working in that resuscitation role'.

CHAIR - Is it fair to say that the flow of nursing coming in so that they can get the skills and be able to work on their own, what you were talking about before and not just having nurses, but having skilled nurses, that there's not enough happening at the recruitment end?

Mr PITTAWAY - Nurses are coming in with experience, but they have to still settle in for a period of time, three to six months, and then they've got to have the opportunity to go through and then upskill to be able to get through to the various roles that we require. It's not unusual for people to come through and have been burnt-out from their previous emergency department experience elsewhere and I've had a number of people say to me, 'look I'm quite happy, I don't want to do resuscitation, I'm just happy staying here'. Well, they can do resus, so I know that they can maybe be given more complex patients coming out of resus. It's not that there's no skills, so you can use those staff quite efficiently, but you've got to be on the ball, you've got to talk to these guys and be a leader in that regard. But having said that, a lot of the staff I believe we're just taking a whole lot of graduates. We're just going to take the graduates, they're coming to the hospital, no questions asked, and that, to me, is a real concern.

CHAIR - For the quality of care of patients as well as the health and wellbeing of the staff?

Mr PITTAWAY - Yes

CHAIR - We've got to finish up but there's just something I wanted to clarify from your submission which is about the effect of ambulance ramping on patient outcomes and one of those you refer to is the delay in medications being administered because it's outside the scope of practice for ambulance staff to do that work. If a doctor wants to give a patient certain medication, but the patient is still under the care of paramedics, is that allowed to occur under the guidelines as they're currently written?

Mr PITTAWAY - If the paramedics decline, that's it, because it's their practice.

CHAIR - Even though they're on the ramp, a doctor from the emergency department can come and give them medication?

Mr PITTAWAY - For the ambulance crews to be happy with that, the doctor would have to stay with the patient.

CHAIR - So, at the moment we've got a situation where, when on the ramp, legally or according to the policy guidelines, the ambulance crew are not allowed to work outside their scope of practice and give a whole range of medications, including certain levels of pain relief, and doctors from the Emergency Department are not allowed to come in and have interventions either, because they're under the care of the paramedics, is that correct?

Mr PITTAWAY - To clarify, the paramedics have a limit of certain analgesics they can give, including narcotics, and once they get to that limit, that's it. The issue is that they're under the care and observation of the ambulance crews. That's it. You're under the care of an

ambulance crew, then if it's outside their scope of practice, the care or the medication will not happen.

CHAIR - Have you observed any conflict between doctors from the Emergency Department and paramedics about that in that situation?

Mr PITTAWAY - Not between doctors. Certainly nursing staff. I'm the fence-sitter there. I understand why the nursing staff want to do it, but also, if those ambulance crews go outside their scope of practice, they're professionally liable.

CHAIR - Have you seen or are you aware of any risks to patients or adverse events that you think might have happened because of that situation?

Mr PITTAWAY - Not officially. I can imagine that any number of people would have their clinical condition deteriorate slightly. The system that we have, you rely on those staff to come or doctors to tell you, or the ambulance crews. That's the whole point, the ambulance crews are supposed to let the navigator know and escalate concerns about patients. Okay, they are the next patient to come up or, if we don't have space in the main department, they come up and we put them in the resuscitation area. We just have to make space. That's our job. We just have to make space. We have in the past gone to patients who have beds in the emergency department area and say, 'excuse me,' and I've done this, I've said, 'can I please ask you to go to the waiting room?' Once they have been in the department, go back to the waiting room, because unfortunately somebody needs this bed. Sometimes that has been mental health patients, too, which is awful. These are the decisions that we have to make, because there's just nothing else we can do.

Then I have staff coming to me and saying, 'this is a problem,' and I say, 'I know. This is my patient here, it's not your patient,' and that is me as navigator looking down on the phone, on the computer, eye on the patient, phone, computer, patient, phone, computer, patient, phone, computer, patient. How good is that?

CHAIR - Thank you so much for everything you have said to the committee. Just a last opportunity for you if you feel as though there is something you haven't said that you would like to say, a particular recommendation, if you were giving advice to the minister that you'd like to make, a suggestion for the committee to look at another particular element?

Mr PITTAWAY - Thank you, but the Emergency Department is not the problem. Please do not tinker with the Emergency Department. Ambulance Tasmania are not the problem. The problem is flow out of the hospital. The urgent care centres, we have what we call the 'mountain area', the GP area, you can see on some days, I've seen there's very few people there. A lot of the urgent care patients, I expect, would otherwise have come to our mountain area, and that's great for them, but it doesn't change ramping at all in my experience.

CHAIR - The unavailability of GPs in the community to provide arranged primary care might have other relationships to peoples' conditions deteriorating, but the people who walk in the door or who arrive for primary care things that could be seen at an urgent care centre, are not having any impact on the ramping. There is no relationship between those two things?

Mr PITTAWAY - No, not in my experience, not what I have seen.

CHAIR - Dealing with the upstairs is the critical issue?

Mr PITTAWAY - Yes, basically.

CHAIR - You have made a whole range of suggestions, and we will take them very seriously and look at them.

Mr PITTAWAY - I remind people that the emergency department is the place of last refuge. Whenever there's a problem, people come to the ED, when there's a problem in the police cells, they bring people to the ED, when there's a problem in aged care, they bring them to the ED, when there's a problem at Salamanca, they bring them to the ED. We get everything, absolutely everything. This happens when ramping is happening. It just never stops. Like I said, the ED is probably the only place where the doors don't close. Everyone else can close their doors. We can't close ours.

CHAIR - Tasmania is really lucky to have a person of your incredible commitment and expertise.

Mr PITTAWAY - There's a lot of us.

CHAIR - Yes, but thank you for what you do for people every day. Thank you.

Mr PITTAWAY - Thank you very much for taking my submission.

CHAIR - Just before we finish up, there's a statement which is about the advice I gave you at the start of the evidence that you gave and just to remind you about the protection of parliamentary privilege which finishes when you leave the table and walk out the doors and is not attached to any comments you make outside, even if aired to the media about things that you've said today. You understand that?

Mr PITTAWAY - I do.

CHAIR - All right. Thank you very much, David.

Mr PITTAWAY - Thank you, Rosalie, thank you everyone.

The witness withdrew.

The committee recommenced at 1.29 p.m.

CHAIR (Dr Woodruff) **-** Before we begin, did you receive and read that the guide that the committee's secretary sent?

Mr EDMONDSON - Yes, I did.

CHAIR - I want to reiterate a couple of important aspects of that. The committee is a proceeding of parliament and that means you get the cover of parliamentary privilege. It's a legal protection that allows you to give evidence to the committee with freedom without fear of being sued or questioned in court or another place outside parliament. That's so that the parliament can get the best information we can in our inquiries. You need to be aware that the protection doesn't remain if things you say that might be defamatory are said by you outside of the proceedings. It's a public hearing today so there might be people from the public watching as well as journalists. Your evidence could be reported so if you want any of your evidence to be held in private, we can take the committee in camera if you let me know in advance and give an explanation.

Is that all clear?

Mr EDMONDSON - Yes, all clear. Thank you.

CHAIR - Great. Would you like to swear to make that official?

Mr EDMONDSON - Yes, all clear.

Mr PHIL EDMONDSON, CEO, PRIMARY HEALTH TASMANIA, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Would you like to make an opening statement?

Mr EDMONDSON - Yes, I would if I can, thank you. Thank you for the opportunity to present and to provide the document that we did through to the committee. Obviously, this is an issue from a Tasmanian perspective that's not unique to this state and not unique to any part of the state. The challenges associated with access to our hospital system and other parts of the system that may cause the issues that we are investigating through processes such as this are well known. They are long lived and they are essentially an increasingly prevalent part of the increasingly complex system of health care that we provide.

Just from the point of view of Primary Health Tasmania, it's important to note that we are federally funded, and we're federally funded in many cases to fill gaps in the system to help link and join parts of the system up in the interests of ensuring that Tasmanians have access to, as far as possible, a whole healthcare system that provides and meets their needs in a way that is least intrusive on their processes of accessing, understanding and receiving the healthcare that they need. In that sense, we work closely with the state Government. We are not directly funded for the greater part by the state Government, but we have a strong role in supporting both the implementation of policy and process in the interests of the integrated system and long-term system reform.

From our perspective, it's important to make a couple of points here. We have got the printed document, but to take that one step further, we believe that ambulance ramping is a symptom of much wider system challenges and issues. If we do, and we tend to - in many respects in response to symptoms rather than causes - try and focus on the symptom, all we'll end up doing is wallpapering over quite significant cracks that exist further and deeper within our health care system. We would urgently caution against responding to ambulance ramping, for example, with wider ramps or more ambulances or more beds in the front end of the hospital in the emergency department. That is not where the problems exist. They exist deeper and further in the system. They exist before patients get to hospital and I will talk about a couple of those.

We understand the causes as they relate to ramping, and in particular hospital access challenges, to be the sorts of things that are probably well known to this committee and you would have heard through a number of presenters, I've got no doubt. Delays in access to care and assessment for aged care and also problems and issues associated with transfer between residential aged care and hospitals.

Access to available beds in the aged care system: there simply aren't enough of them in the places that people want them. We have, for better or worse, a system that allows individuals to make choices, right down to the location and the facility that they go to.

Over time, we may need to reconsider how some of these things actually work in the interests of ensuring that we can get full and the best utilisation across our system rather than just acceding all the time to choices that individuals want to make. I understand the reason they want to make them, but sometimes it's just not practical to provide those sorts of choices to the level that individuals might want them.

Primary care cost impediments: these drive populations to the front door. We know that. Certainly, as a long-term servant of the primary care sector, we know that issues in relation to access and cost for general practice are things that cause people to seek out the front door of a hospital as their preferred primary care provider simply because they know they won't be turned away and they know there is no cost attached, regardless of whether they have to wait six or eight hours or otherwise to get service. Unfortunately, that's just a reality in this system.

I think the absence of a user cost for ambulances in Tasmania is something that we need to consider. We are one of the only states that doesn't levy a consumer cost. Whilst I baulk at any suggestion that increasing costs to consumers is a good thing, in some respects the notion of having a cost allocated to something like calling an ambulance does cause people to stop to consider 'Is this actually what I need? Is there an alternate for me?'.

This brings me to the next point. That is, the fact that there is a great difficulty for consumers and the community in accessing information about what services are available to them in the out-of-hours period. There are quite a lot of them. It's not simply the case that it's either a GP that's closed at night, at weekends, or a hospital. There are a number of services now available to the community and their ability to actually understand what those services are, their eligibility for them and where they're located is a very, very difficult thing to navigate. Even with services like Healthdirect nationally, we still find that we have a range of different services locally that are simply not known to people and they're often not known to providers either. We need to have a better access to the front door. So, the centralised coordination and integration, if you like, is essential in this process as well.

Then, there are the obvious discharge-related challenges at the back door of hospitals that make it difficult for beds to be freed up for people to access and keep that flow moving through. Again, there are people much better qualified than me to speak on those particular issues. These all create the bottlenecks and the challenges that result in the front-end, very public and visible issues of ambulances lined up on ramps.

The other critical disabler for our system is, I believe, the absence of a single electronic health record. What we have is an environment where the health information of consumers is stored in a variety of different locations in their hospital record. To be quite honest with you, that might be in one of three different hospital records in the north, south or the north-west, none of which communicate with each other.

It could be in an ambulance record, which is a separate system again. It's not accessible to others outside. Ambulances can't see, with any sort of sense of purpose or immediacy, records that are held in other locations for patients when they respond. And, it's held in the computer systems of hundreds of GPs, thousands of GPs across the country, all of which are individually and independently stored and not accessible to anybody else.

This issue of single patient access, or single record access for multiple services is something that I believe our system needs to seriously explore, noting, of course, that there are processes under way to implement this.

The Tasmanian Digital Health Transformation Strategy has, at its core, some of these key elements of reform. We would be urging and strongly encouraging those things to be brought forward. They are in later horizons as that plan details them and we believe these are the sorts of things that could potentially be brought forward if resourcing was available to support that.

We think, realistically, we need to turn our attention to other causes. I would urge this committee to be looking behind the front-end challenges that present in pictures in the front page of the paper.

The aged care system, and obviously in the context of national reform, the Aged Care Royal Commission, there are a huge number of issues that contribute to challenges in the aged care system. We believe that the availability of higher capability nursing resources in every facility for 24 hours is a good initiative, but we have to change long-term and entrenched behaviours. That will not happen overnight. Just simply putting a resource in there will not stop a facility from going down the usual path of calling an ambulance when a patient first reports something, that they go, 'Oh, that might be a bit of a problem,' instead of undertaking, for example, an ECG in a residential aged care facility, immediately jump to the phone and saying, 'Look, we haven't got enough time, we haven't got enough resources; we're going to put them in an ambulance and send them off'.

That, unfortunately, still characterises behaviour in the sector across the country. That's not unique to Tasmania either. That avoidable transfer focus is something that we've really got to sort of turn our attention to. That needs a really strong partnership between the residential aged care home sector and the state.

The afterhours care access I've touched on already, really that sort of coordination about multiple touch points.

We have Health Direct, we have Ambulance Secondary Triage, we have GP Assist, we have extended hours mental health services, for example, in some locations increasingly as part of the Health Care Homes Program and the Head to Health Program nationally. We've got a number of options available to people but the intuitive initial response is to go with what we're used to using rather than looking and then exploring some of these other options.

We need to make these people aware of them so they actually prompt others making decisions about where they should direct them to those options - that single front door access has to be provided. These all sit in isolated locations. Unless you know how to contact them you're not going to go down that path. It's much easier to dial 000.

Virtual care: I mean, the state is investing heavily in the virtual care space. The virtual care responses need to be strongly integrated with these other elements of care in the system as well. Again, it's all about coordination, it's about information sharing, it's about communication, and the person who gets forgotten in a lot of that process is the person who's on the initial phone call to a helpline seeking a response. Often that will be a 000 response. So, we need to support that with really good community information and community support.

I think that probably about ends what I'd like to focus on, but I think those are the things that we really need to be turning our minds to. We've got the capacity to do that in a state where we have a single hospital system, a single primary care coordination structure, a single ambulance system. We've got all the hallmarks there to be able to do this stuff, but in many cases, the challenges associated with resourcing, change management, et cetera, often drive us down investment in one or other to the exclusion of other elements. That is probably all we'd like to say upfront, in addition to what we've said in the paper there. Thank you.

CHAIR - Thank you, Phil. I appreciate your breadth across this area and the fact that you work in so many areas, so your submission's really helpful for the committee.

Before I start asking, a point of clarification about the first part of the submission, something you said in your opening statement. You said that the main drivers of transfer care delay in Tasmania are increasing urgent and non-urgent demand for hospital emergency services. The committee has heard and we understand from the data that it's not the non-urgent care that's actually a problem with transfer of care delays because those people would be going to the emergency department waiting rooms and wouldn't be looking to be waiting in line to get a bed upstairs. Can I clarify your thoughts on that?

Mr EDMONDSON - I'd love to think it was as simple as that but ultimately, if we look at it like a digestive system, you can swallow your next mouthful when the first mouthful has moved on and unfortunately that's how our system works. Same as bases in baseball: once you've got all the bases full, you can only move when everyone moves. That's the problem we have in our system so often. The system is dependent upon the next part clearing out and making available space within it; that's how our system works.

So, if we have a blockage or a restriction somewhere, that holds everything up on the way through. It would be nice to think that we had different pathways for urgent and non-urgent. And, yes, it is fair to say that we do, but ultimately, in a hospital access sense, in an unplanned admission sense, they all come through an emergency department access point.

CHAIR - The ambulance bay?

Mr EDMONDSON - They all come through that space. The reality is that if there's no space in there for them, they wait outside. And then it's a case of the paramedics having to make decisions about - sorry, the hospital system - about the triage process, having to make a decision about which one is most urgent.

Look, it's not as simple as that, we do have a mixture of urgent, non-urgent. The reality is that regardless of urgency of a person who turns up in an ambulance, they are considered to be of a higher priority than many others who might be sitting in the waiting of an emergency department who may have made their way there by their own accord.

That is the other issue. We have a largely patient-driven determination of whether I think I need an ambulance or not as opposed to a mechanism that sort of controls that a little bit more. I think we are getting better at that, we've got the emergency care paramedics, we've got secondary triage mechanisms that try and control that, but ultimately we still have a system that is largely patient driven in relation to a 000 call or access to another point.

CHAIR - Doesn't this start with a 000 call and the people picking up the phone in the 000-call making a determination about whether an ambulance is required?

Mr EDMONDSON - Yes, it does.

CHAIR - Aren't there other options for them to call on? For example, an urgent care centre?

Mr EDMONDSON - Absolutely.

CHAIR - Is the problem happening at that point?

Mr EDMONDSON - It is. I would hazard a guess to say that there are some who know what to say in order to get transport. It's easy to be able to explain your needs in a way that's going to get you what you want if you know how to use the system in that way.

Urgent care centres are very proximally based. They're close to hospitals. They're not going to solve the problems for the person living in George Town, or the person living down the Huon, largely. They're not going to solve those problems because, ultimately, once the person's got to travel, the urgent care centre is an option if it's available, but if it's outside their hours of operation or otherwise, it's not really an option.

At the moment we're too early in the urgent care centre rollout to have any real idea about whether urgent care centres are going to positively impact - I'm assuming they're going to, but I don't think they're going to impact to the extent where this problem is going to go away.

CHAIR - Also, the converse of that is if people feel that they can't call an ambulance, or if there's a cost to calling an ambulance, and Tasmania's got many vulnerable people from poverty or health points of view, who would be disinclined to pick up the phone, would you say that the people who might be - from what you said, almost 'gaming the system' - to be able to make sure that they get an ambulance? They'd be in that small minority, wouldn't they?

Mr EDMONDSON - Yes, and there are people much better qualified to talk to this than I am, but you frequently hear stories about people who will ask an ambulance to stop, and they will get out of an ambulance a couple blocks before the hospital. There are these sorts of things that happen.

CHAIR - Okay, we will follow up on that.

Mr EDMONDSON - They're the sorts of things that do occur. I am not suggesting for a moment that that is the way in which the general population treats it. I know the challenges associated with raising the concept of a user-pays fee for an ambulance. All I was suggesting is that if you put processes in place that cause people to think, 'Is an ambulance the best thing for me?' that may positively impact the number of calls that an ambulance service receives. I'm not qualified to comment on that beyond that, but I would say all of these things are subtle elements that lead towards a heightened use of a service.

CHAIR - In the discussion about bed capacity, in your submission you talk about the need for a long-term focus on increasing the primary care capacity in Tasmania as well as interim solutions. On the longer-term element you talk about development and utilisation of expanded workforce models. Can you explain what you mean by that?

Mr EDMONDSON - I remember there's a very good example, one that we are running in the north of the state at the moment, called Healthcare Connect North, where we've effectively funded the Launceston General Hospital to identify patients who are high users, high volume users of beds in the hospital environment. We offer them a wraparound service that takes them out of that bed but provides them with some of the things that ordinarily they would only get if they were in a bed. It's not a hospital-in-the-home arrangement. It is a community accessible service that supports people to think that there is an option to support their needs that doesn't involve them in beds.

In many cases what you are talking about here are people who become habituated to hospital use. They become habituated because they're lonely, they don't have people to care for them or support them at home, they often have a range of other needs that sit around the outside - mental health, health literacy challenges, et cetera - that contribute to their general feeling that they are not in control and that they're not able to control their own outcomes. So, often hospitals are a good point for them to go, and they feel comfortable that they're being looked after and supported there.

Does their condition often require them to be in a bed? In many cases, what we find when we look at that particular client or patient group, they don't actually need to be in a bed, or they certainly do not need to be in a bed as frequently as they are. This service takes them outside. It offers them an alternative, and it provides a sort of wraparound support that includes often the sorts of things that we don't generally associate with health system response typically - social work type support, re-engagement at a community level with other groups and supports to address some of their socially determined needs.

CHAIR - That sounds like a great model. I was interested in your comment about development and utilisation of expanded workforce models.

Mr EDMONDSON - Sure, what that does is seek to place - and when we talk about expanded workforce models that is placing a general practitioner skill set inside a typical

hospital environment. So, what it's doing is - that's what we do with that service. We're trying to change the perception of the need for medical versus other allied health support there, so the bulk of that service is provided by the social worker and the nurse. The medical oversight component is very small. It's important that it's there because the level of complexity that often drives patients to admissions that are long and frequent is often beyond the realms of somebody in a normal general practice environment to be able deal with the normal fee-for-service arrangements.

CHAIR - Is that a model that is being proposed for elsewhere?

Mr EDMONDSON - That's certainly one of the aims of that model, to build a case for a block-grant funded approach that we could then apply across other regions.

CHAIR - When would that be, when would you be hoping to make that?

Mr EDMONDSON - We are currently working with the state around the development of that case, based on the evaluation work that's being done as part of the implementation of that model. We're working in partnership with Menzies around that evaluation.

CHAIR - In the next year, or two years?

Mr EDMONDSON - Absolutely, it has to be in the next year. We only had funding for two years for that service, so its continuation is dependent on our ability to actually mount a case to the Independent Hospital Pricing Authority for that.

It's the same sort of concept that's been applied with the ComRRS - Community Rapid Response Service - approach. Other models, in terms of expanded workforce, there's the nurse practitioner-based options. Obviously, they have a scope of practice that is a little more restricted than it might be for a medically trained professional, but there is certainly, I think, in a partnership-based model or a collaborative model, opportunities for people other than medically trained professionals to be in a position to respond and support.

CHAIR - This has been discussed as long as I have been an MP and well beforehand, so we're talking more than a decade now, but there hasn't really got traction. There's been very, very few cases - Cygnet's the only one I can think of in Tasmania - despite at least 14 years of having these conversations. What do you think the hold ups are and what can happen at the state level about that?

Mr EDMONDSON - The hold ups are the funding issue, the funding challenge. There are obviously other issues that come into play there, scope of practice, capability to respond. There is an issue in relation to access to nurse practitioners. We don't have enough of them, but that's probably because we don't have an employment structure and a workforce model that extends to their involvement in a range of areas where they could be involved. Look, there is a range of factors contribute to it; the primary one I would venture would be the absence of a funding model that supports nurses to provide that level of independent care.

CHAIR - Thanks, I've got another question then I'll go to Anita Dow, who's online. Just so you know, the members - Anita Dow, Lara Alexander and Simon Wood - are online.

Are you aware of a THS strategy that's already under way to expand workforce models?

Mr EDMONDSON - Yes, certainly. There are a range of things that are currently underway that the THS is implementing.

CHAIR - Do you think they are adequate?

Mr EDMONDSON - It's very difficult to say, too early to say. The problem is, the issues associated with challenges such as workforce traversed by federal and state divides. You've national workforce strategies in areas like mental health, et cetera, that are being implemented now. The relationship between the state and federal governments is largely the plaything of the national health agreements, which I understand are being renegotiated at this present time.

The problem in our system is largely that we have multiple responsibility. There are multiple parties responsible for single areas and the extent to which those parties are able to collaborate and agree has long been one of the challenges that we have in health. We straddle this fence on a daily basis. We're federally funded, but principally our primary partners in the system are the state. We often find ourselves in a very uncomfortable space in which there is no clear indication of who is responsible for what.

A lot of it is to do with collaboration and partnership and that's often not easy to navigate or to generate. I couldn't answer whether the current strategies are going to have significant input or significant effect or impact on this particular issue. I think if they are starting to address some of the causes rather than the symptom, then I think there is a chance that we might be able to address this long-term, but it's only going to be working across each and all of these areas, I believe, that we are going to find a genuine and sustainable solution to this particular issue of access.

CHAIR - Thanks. Anita?

Ms DOW - Hi, Phil. Thank you very much for joining us and thank you, Chair.

You spoke a lot about the need for investment in community-based services, and I know that the primary health network in the past has worked in partnership with the state Government to provide a number of initiatives. Where do you see opportunities for the primary health network to work more closely with the state Government to undertake trials or place-based initiatives? They're things that you mention in your submission to our committee. You provided a number of examples of things that are happening in other states, in particular, what a primary health network is doing in Western Australia around urgent care centre trials.

I'm just interested to understand how, as our primary health networker, you fit into this system and how, perhaps, a state government could be working closer with you to try and provide some of these solutions in community-based care before people have to call an ambulance or present to an emergency department, or be provided an alternative model of care in their community rather than in a hospital?

Mr EDMONDSON - Sure. That's a really good, or that's a very complicated question, but there are a number of good parts to it. I mean, I think we have a really strong working relationship with the state. What we have in Tasmania is a poor investment of the state outside its own system. What I mean by that, is that in states like Western Australia, New South Wales,

Victoria there is significant investment by the state in working in partnership with organisations like primary health networks to implement a number of those models and services.

What you will find is that in most cases and the sorts of examples we have raised here, you will find that the state is actually investing in the primary health network to drive some of those things, but they don't have the wherewithal or the capacity to do. Working in partnership is often what drives some of those successful interventions.

We don't have a significant investment from the state in the primary health network here. We know that we are a system that works on the smell of an oily rag. We don't have the same resourcing flexibility that some of the larger states do, so we understand that. Often, we find that we're the ones who have to invest in these things to prove that they work prior to the state taking them on.

The service that I was referring to in the north is entirely funded by Primary Health Tasmania. We've invested $ 2 million in that Healthcare Connect service in the north, but we paid that to the state. So, we're paying the state to run that service within the boundaries of the Launceston General Hospital because we believe that that sort of community response model where people can actually receive support outside of a hospital bed is critical. We've taken the initiative to invest in that.

We would like to see more investment from the state in working in partnership with us to deliver some of these things on the ground with community-based services, but we don't find that there is a strong will to find the resourcing to do that. Often, we find that the state will take those things on and do it themselves if they are willing to do it but there isn't the significant example of that for us here. That's long been the concern that we've held as a primary health network.

I guess the other thing that's worth bearing in mind in relation to these services interstate is that a lot of them have innovation-type funding resources. Queensland, for example, when you look at the community care coordination model, and again, this focuses on those with complex chronic needs, they are taken outside the hospital system. The state funds the primary health network in Brisbane to actually employ and engage care coordinators who work with those patients, those clients at community level to reduce their dependence on hospitals to prevent avoidable admissions.

Again, the state has chosen to fund that because it knows that reduces demand on their beds. Even though we know that the system only pays people when they occupy beds, it's ensuring the right people are in the beds, who need to be there, as oppose to the wrong people who shouldn't be there. That's another example of investment but that's through an innovations fund. Again, we don't generally have that type of funding in existence at the moment in the Tasmanian system.

Ms DOW - Do you think that that was a good inclusion?

Mr EDMONDSON - I think it would be a fantastic inclusion. We are only going to solve these problems if there is a mechanism for us to think outside the square. The unfortunate reality is that the mainstream funding that comes into the system through the National Health Reform Agreements comes with very heavy silos and rules attached to it. Often there isn't the

flexibility there to be able to use that funding in a way that responds most effectively to the need at hand.

From our perspective, we would love to see the innovation fund supported. We would love to be able to engage with the state on truly outside-the-square thinking. That's what's required for a group who are very difficult to service without normal mainstream structures and processes.

Mrs ALEXANDER - Thank you, Phil, for attending the hearings today and providing the opportunity to ask some questions. You've got a wealth of knowledge. Having spent some time on aged care myself, I'm particularly interested to hear your view on whether Tasmania with its ageing population has an adequate of aged care beds available for the population?

Mr EDMONDSON - That's a good question and I'm probably not best placed to make a really informed judgment about that. Aged care is not my speciality space. What we have is a challenge associated with beds in places that people want them. Whether the overall number on the basis of population is adequate, based on our population characteristics and complexity and age, I'm probably not best placed to comment on, but I think we do have an issue in ensuring that we have those beds placed in the right locations.

The challenge we've had under the universal access system is that when people have absolute freedom of choice, under the current medical service system - and I'll give you an example that's urban based. You have an environment where you might have a residential aged care facility where 20 different doctors from 10 different practices are providing services to the population of that facility. That's great if those doctors have the means and the capacity that when the need arises to respond quickly and easily by upping themselves from their practice location and going to the patient's bedside in the facility and dealing with that particular need. That's what's required in order for the payment for aged care work: the doctor has to attend the facility and it can only be the doctor.

You can have five different doctors in the facility seeing five different patients at the same time. That to me makes no sense. I would love - and I'm going to characterise this as a personal view - to align practices with facilities. That would ensure that they can access services much more quickly and they could access them in a way that prevents a facility seeing an escalation and feeling that the only option available to them is to move them to a hospital.

That to me would work much more effectively. I believe also that we need to be moving to a system that allows a practice nurse, where a patient has a planned approach to their care to be able to respond on behalf of the practice, rather than the doctor having to turn up, which facilitates the Medicare payment. We've got a load of structural challenges and issues. I believe that we have a reasonable number of beds. We have a number that are not able to be used because a patient can only move into a bed when they have a GP who's willing to take their care.

If there are no doctors in that particular area, or that doctor doesn't have the capacity to take on more patients then, to all intents and purposes, that patient can't move into that bed. That's just the way our system works.

There are some really fundamental structural impediments that I think need to be resolved in the way in which care can be provided and the way in which care should be provided.

I would love there to be one facility, one practice; and the doctors in that facility and the nurses in that facility are equipped and supported to be able to go into that facility two or three times a week, see patients on an as-needs basis, be able to respond urgently when they can, and to manage their after-hours care needs as well.

That, unfortunately, is not the way in which it works at the moment. I can tell you that young doctors coming to the system do not want to deal with the system as it's currently structured. They do not want to be having to uproot themselves, provide 24-hour support and back up for older patients in the way in which the system is currently structured. Look, we've a problem now, it's going to get worse unless we resolve some of these impediments.

Mrs ALEXANDER - Exactly following on that, Phil, I think you basically hit the nail on its head, is that there are some significant changes that need to made within aged care - also the Aged Care Quality Standards - because what you've mentioned around preventing unnecessary transfers from aged care to hospitals, which is what should happen. Correct me if I'm wrong here, from your presentation and from my experience as well is that the accreditation standard, especially the quality standard no. 3, specifically talks about responding to deterioration. There's actually quite significant penalties if facilities do not demonstrate how they respond to deterioration, which basically involves move them quick to a hospital. Is that your experience or what you've heard as well in looking at this issue as a broader issue?

Mr EDMONDSON - I probably can't comment in too much detail around specific instances as they relate to a particular standard but what you say is absolutely right. If a patient is starting to deteriorate, there needs to be a response that's timely and appropriate. If a GP can't be called, or the GP is not willing to attend, then the only option available to the facility is to transfer them.

My question would be around does a facility have the right equipment to be able to, say, for example, put a trace on a person's heart to see if they've actually had a cardiac event as opposed to mild indigestion, angina or otherwise. Invariably, you're right. Some of the rules and regulations drive us to decisions that ordinarily we might not make if there wasn't some sort of penalty or challenge attached to it. Again, these are all contributory elements to that. That escalation, rising risk monitoring, is one thing that would much better be able to be managed if you had a regular attendance and relationship by a practice within a facility. They could monitor this stuff much more regularly as opposed to the present time where they call a doctor only when there is a sufficient symptomatic requirement for them to attend and to meet a patient face-to-face.

It's just not a system that's well-structured for good, quality care. It's not the system's fault; it's not the GP's fault; it's not the patient's fault - it's elements of the structural impediments with the rules, regulations and mechanisms to provide care.

CHAIR - Phil, I want to talk about your submission's comments about the availability of ambulance ramping data. You described the importance of sharing that information. Have you approached the THS or Ambulance Tasmania to access the information you need and, if so, what was the response?

Mr EDMONDSON - No, we haven't. Generally speaking, this isn't an area that we tend to involve ourselves in heavily. We have a data and analytics response that we create and develop - a needs assessment, comprehensive needs assessments for the state. We use available

information and data that's provided for us. There is no regular reporting mechanism for this type of information.

CHAIR - You haven't asked for it?

Mr EDMONDSON - We haven't asked for it but it's not something that's publicly reported with other data in the same way that, say for example, wait list times are for inpatients.

CHAIR - You also said that the information about ambulance ramping is communicated through mainstream media and social comment with little information available to primary care services about hospital capacity and level of operation.

Mr EDMONDSON - And it is after the fact.

CHAIR - Can you explain why that lack of information matters?

Mr EDMONDSON - Why it matters?

CHAIR - Yes.

Mr EDMONDSON - I guess what it allows you to do in an immediate sense is monitor as things start to increase or rise if it's available in that particular way. Generally speaking, what happens is it's reported after the fact. When there were 20 ambulances ramped up on a particular night, that's what you see, that's when it's reported, that's when the explanations are created, et cetera. I am not sure what would be the best mechanism to report this information.

CHAIR - You had some suggestions about health dashboard.

Mr EDMONDSON - But if providers knew - if this information was available in real time through a dashboard or otherwise - if there was an ability to see at any one point in time how busy a particular facility was or otherwise, I think it would give those in positions to make decisions about whether calling an ambulance might be advisable or not an additional tool, if you like, to help them make that decision.

CHAIR - Such as aged care facilities?

Mr EDMONDSON - Exactly. There is nothing better than information available to people to actually improve the quality of decision-making, and when it's only available through reports because it has been identified as a major issue, or a challenge has occurred on a particular night, it's just not a good way for information to be shared.

CHAIR - Real time reporting does happen in other jurisdictions?

Mr EDMONDSON - I couldn't answer that at this point in time. My understanding is that there are some jurisdictions where that is reported. There are some private hospitals that run emergency departments where that is reported. The extent to which it's widely available, I'm not certain. I mean, the code reporting, for example, when hospitals have particular codes of response, those are communicated as those codes are raised. For example, if access issues become so severe a hospital has to erase its coding, the coding is reported, often to primary care, and they're advised, you know, 'the Royal has a code black', so, you know, access is highly

limited. I don't know if that is the right colour code, sorry, don't take that as a given, I'm not familiar with hospital colour codes, but I know that it is something that has been reported through using existing information systems to primary care providers, for example.

CHAIR - Thanks, and you list some short-term actions in your submission. I will read out one for people who are watching:

> Ensuring Ambulance Tasmania and community pharmacists are connected to and using My Health record system to upload patient care summaries and the Tasmanian e-referral system to communicate with the patient's regular GP which may reduce readmission for non-emergency care needs in the future.

Can you give us some more information about how much of an issue you think re-admissions are and is that increasing?

Mr EDMONDSON - I couldn't tell you whether it is increasing. As complexity of care increases so, generally speaking, do the frequency of avoidable admissions or preventable re-admissions. What I mean by that is as you have more people who have higher complexity care needs, the likelihood of them being re-admitted does increase. On a statistical basis that can be an assumed outcome. Having said that, I guess the opportunity to intervene differently for people who have either rising risk, measured rising risk - and we've got areas like cardiac care where the measurement of rising risk - cardiac risk - is something that is now routinely measured for patients in a general practice environment.

As you are able to see care complexity change and the risk rise, you can respond differently. But again, it's to do with the information that you have available to you. The issue for Tas Ambulance, for example, is that - my understanding is - they can't yet upload information from the VACIS system which is used by Ambulance. They can actually see information in My Health record, but they can't upload information from the ambulance system to it.

CHAIR - So that was a question about the use of digital systems at the moment.

Mr EDMONDSON - It's an incomplete record and it's a series of pictures. My Health record is a series of PDF pictures. There is nothing intuitive about the data, there's nothing current about the data that's entered from either general practice or any other point at the present time. There are some functional changes required to the My Health record and I know minister Butler has said loud and clear that he intends to re-platform the system and intends to move it away from that current visual image to a much more intuitive database system.

There is a range of issues there. They're not the Tasmanian Government's fault, but we have that disjointed data environment that means it's impossible for one person to see a complete picture of an individual's utilisation of the system which makes it very difficult to make pre-emptive decisions about care.

CHAIR - So fair to say that it's a very incomplete system, that it's currently very underutilised, it has a great deal of potential and it's something that the state maybe should be strongly advocating for getting that change at the federal level?

Mr EDMONDSON - Yes. I would also like to see an integration of ambulance data with the Tasmanian patient record in a way that is much more intuitive than it is currently. Ambulance data - my understanding, is still stored in Victoria, so the Tasmanian data sits in a Victorian system. I would stand to be corrected there, but that's what I understand at the present time. It doesn't sit within the Tasmanian system itself.

CHAIR - So it can't connect in?

Mr EDMONDSON - I'm not saying it can't connect in. What I'm saying is that there is a one-way view to that information at the moment. Ambulance paramedics can actually see the My Health Record; they can see what information is in their system. I believe they can dial into the Tasmanian patient record system. I don't believe there is immediate upload capability into the patient's record within the Tasmanian system. I could be corrected on that.

CHAIR - Something for the committee to follow up on. We've got to finish soon, unfortunately.

Mr EDMONDSON - Sorry, yes.

CHAIR - No, don't apologise, it's been really helpful. I think Mr Behrakis had a question.

Mr BEHRAKIS - Thank you for coming. Just on the same train of thought of these databases, is this something that's seen in other jurisdictions, this sort of issue? I would have thought, in the current modern age, everything's digital, everything's wireless and over the internet and instantaneous. So I imagine this isn't a problem just in Tasmania or Australia. What about other countries that have numerous states, like the United States? Is this an issue that's being seen around the place as people try to adjust to this, or have people kind of worked it out and we're behind the eight ball on that?

Mr EDMONDSON - The United States is probably not a good example because they have disaggregation in other ways, but they probably do have, because they have generally a single health manager who does have pretty much end-to-end view of that particular individual's health information. The UK, for example - these are countries that all have a single health identifier. We don't have a single health identifier. We have a Medicare card, but that is used -

CHAIR - Nearly had one.

Mr EDMONDSON - We did nearly have one.

CHAIR - Twenty or 25 years ago, actually, in Western Australia.

Mr EDMONDSON - And we have never gotten close to it since. So, we have a Medicare card and its legislative use is only for national overall data collection against individual provider instances of care. It is used to monitor and manage the payment system for doctors. We don't have a single identifier and that is our fundamental downfall, I believe. If we had a single identifier across primary, tertiary and community care, our ability to understand how patients move through our system, where the blockages and challenges are, becomes so much more a reality.

Other states are moving down the path of a single electronic health record, but again, we've that divide between publicly funded services at the state level and then the accessibility to privately held records in general practices and private specialists. There is no really good example of full integration in Australia, but there are examples of partial integration at least for state-level services. I know that is part of Warren Prentice's roadmap for e-health. How quickly we can get there and how inclusive that is is really the question. We would like to see that accelerate and move forward. Ultimately, we think the communication, information is power - as we know - and power in the hands of people making critical decisions at critical points in individuals' lives is really important.

CHAIR - I am afraid we have to wrap up now, which is a pity because we could keep talking about this. You've got such great experience and expertise. Thank you very much for presenting to us.

Mr EDMONDSON - Thank you very much, and I appreciate the time.

CHAIR - Before you leave, I want to remind you that everything you said today is protected by parliamentary privilege. When you leave the room you need to remember that the privilege does not follow you when you make comments to anyone outside, including the media, if there was anything that was defamatory in that regard.

Mr EDMONDSON - I don't intend to defame anybody.

CHAIR - No. Even if you are just repeating what was said here, just so that's clear.

Mr EDMONDSON - I understand. Thank you very much.

CHAIR - Thank you very much for appearing.

The witness withdrew.

The Committee suspended.

CHAIR - I will introduce people on line - other members of the committee: Lara Alexander, Anita Dow, and Simon Wood, and Simon Behrakis.

Before we begin, did you receive and then read the information that the secretary gave about parliamentary privilege? This is a committee of the proceedings of parliament. It means that you get the cover of parliamentary privilege. There is a legal protection around that which allows you to give evidence to the committee without being sued or questioned in a court or palce outside of parliament. That is so we can get the best information that parliament needs for our inquiries. You need to be aware that the protection doesn't remain if you say things outside which could be defamatory, even if they are things that have been said in the hearing.

It is a public hearing today and there could be people from the public or journalists watching online or coming into the room. Your evidence could be reported, so if there's any information that you want to be said in private, off-camera, then you can let the committee know in advance if there's a reason for that and we can go in camera at that point. Is that all clear?

Dr LUMSDEN-STEEL - I'm happy, I have received the information.

Dr BARRATT - Yes.

CHAIR - Thank you. You've both got cards, there's another one over there. So, if you could both read that.

Dr ANNETTE BARRATT VICE PRESIDENT, AND DR MICHAEL LUMSDEN STEEL, BOARD MEMBER, AMA TASMANIA, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Excellent, would you like to make an opening statement?

Dr BARRATT - Yes, thank you very much for asking the AMA to comment on this issue. It's one of vital importance to our members and when we sent out an invitation to membership to comment we had an unprecedented number of members who sent comments, passionate comments of concern, so this is a major issue to our membership across the state. It's one that they are passionate about and one that they are concerned about the emphasis being on ED and ambulance ramping when we are very much of the opinion that this is a whole system problem.

That the ambulance ramping in the Emergency Department is a symptom rather than a problem in itself and we've gone into various parts of that in our submission, which we assume has been read. I will be handing over to Michael who currently works within the hospital system. I'm a general practitioner by trade and I see part of it, but Michael sees more of it and I'll be happy for Michael to do most of the talking.

CHAIR - Thanks, Annette, and yes, we have read the submission. That's the background for which we ask the questions today.

Dr BARRATT - Thank you.

Dr LUMSDEN-STEEL - I'm an anaesthetist. I work in both the public and private sectors. I've also got visibility through my work with the AMA, [inaudible] and the Society of Anaesthetists as to what happens around the state as well as what happens around the country.

This is about the patients first and foremost. Doctors have this intangible relationship through life. Obviously, as you know, we're involved from the pregnancy phase, even to help patients get pregnant, right through to growing up, middle age and then during, often, the final stage of their life. So, what we know is the demand is actually known and if we report and get that stats on it we can find out what the demand is for pretty much most areas of medicine that we have. The question is, how transparent is that data? The next thing is we know that demand is increasing and the predictions at the moment that are publicly available suggest that we're going to have a population round about 650 000 by 2030. You will have other intelligence and data on that, but our population is growing and that's only going to see an increase in demand.

It is unacceptable that patients continue to be ramped and cared for by Tasmanian Ambulance Service crews due to the Tasmanian Health Service continuing to be under-funded, but it's not just the Tasmanian Health Service, it's primary care and general practice. As Annette has said, ramping is a critical symptom of a health system that has no redundancy and no surge capacity. At the moment from time and again and from the submissions I know you've had so far and from what you've been told, we stumble from one crisis to another and it's almost like we're just recovering from one crisis and then another one rolls on too.

This is not a failure of any individual person or any individual government, but it's a failure over all levels of government, state and federal, over many years who have failed to have the frank and fearless discussion with the public service - that's the health bureaucracy - about what the true demand on health care services is and with the public about where there is a health demand, what are the levels that the government is prepared to fund? If we have an expectation we're going to provide the care that we do, how are we going to pay for it and what's it going to look like?

The issue is, at the moment the most disadvantaged are those with chronic disease, those from a low socio-economic background, those with low health literacy and those living in regional areas. These are the vulnerable patients who rely on our public system and they've got no capacity to actually navigate healthcare via other options, which can be paying for it privately or even going interstate for care. They're relying on us providing the service for them. Those with the capacity to afford private have the option - and many choose to do so - of seeking out private healthcare both within Tasmania and even flying interstate for care.

I hope this parliamentary inquiry should also be looking at accountability. One of the challenges we have to do is you have to ask the tough questions to be able to produce an honest and accurate position on what the actual health service demand is, what the key funders are for the area and what's their responsibility, and what the funding truly needs to be to provide that service. Because only then, if we have an honest and open discussion and investigation, can we actually look at what the healthcare funding shortfall is.

This is, as a healthcare worker, and I know you've heard submissions about people working in environments that they feel are moral damage, moral injury, unsafe, unsustainable, but how do we take the politics out of our healthcare funding? At the moment, we have solutions that are often driven by political short-term goals and gains, and it's to do with funding. And, unfortunately, sometimes it's associated with election cycles. Until we actually

do this, how can we have a true and meaningful conversation as a state and, obviously, and as a population about how we are going to fund the solutions that we all know exist? Because it actually comes down to funding.

Just some comments about the THS. Having worked in the healthcare system and having been a medical student working and being in the Tasmanian healthcare system since 1995 - and we've had discussions before in our community about how we've seen the actual problems just continue to get worse every year, and there's been no actual true acknowledgement that as demand has increased, the services have not increased to meet demand. I think it's a good segue just to quickly just take us - the primary healthcare service going back 20, 30, 40 years ago was well-funded in terms of the GP rebate being sustainable for patients to be no gaps.

Annette, this is your chance to speak to that.

Dr BARRATT - When I started in general practice, which was 40 years ago - I had my 40th anniversary - the Medicare rebate was 85 per cent of the AMA fee. Therefore, if the doctor decided to bulk bill a patient, they were losing 15 per cent, which is doable. It's now 42 per cent.

CHAIR - Less than half.

Dr BARRATT - Less than half. So, if you bulk bill a patient - and we had a generous increase recently of 41 cents per consultation - and you can't do it, and if you're in the city and you do the triple bulk-billing incentive, you get $18. So, if $100 is the recommended fee, you get $41 from the Government, you might get the $18, it still only brings it up to $58, $59, not the $100. It's just over half. Why should GPs do that? We are aware, as a GP, that we are preventing the vulnerable patients coming in. That's not what we want to do, but we also have to pay our own bills. We have to pay the Hydro. We have to pay our staff and we have to pay for consumables. Dressings do not suddenly appear from the dressing fairy.

CHAIR - Everything has gone up.

Dr BARRATT - And everything has gone up. This impacts ramping because patients don't come to us until they are sick and then they go to ED and instead of being treatable they are admittable. That is where the extra pressure comes, from my side, which leads to what Michael sees on his side.

Dr LUMSDEN-STEEL - And this isn't GPs saying it is about money. It's about sustainable services. GPs are a small business, and we know that during COVID-19 and with health CPI - health CPI runs at around about 6.8 per cent, it's often running higher than what normal CPI is running at. During COVID-19, the sourcing of extra PPE consumables, dressings and navigating Medicare is incredibly complex. There's initial consultations and there's fees for follow-up consultations.

One of the dilemmas that we have is that - getting back to GPs - GPs prevent things and they can manage a lot of things, but as that has devalued, that work that GPs used to do isn't done by GPs anymore because it's not sustainable. It's been pushed into the public system, when a lot of things could have been managed by GPs. I don't mean to labour too much on the point, but other than GPs actually by early prevention actually maintain healthcare. They get patients, they diagnose conditions early, they treat hypertension early, they help with patients

on their journey with chronic disease and they prevent the adverse events that see them come into hospital when they are untreated.

Once you get into hospital, it's expensive care. The moment you step into a hospital facility or get admitted or have surgery, and that's obviously the last resort, then things become a lot more expensive. So, the preventative care that's provided in the community, and we have to accept that some patients, you know, may not be able to afford to pay that $20, $30 gap which GPs now must charge to be a sustainable service. This comes back to the federal government not being held accountable for what they are doing for patients. If they want patients to be paying for their primary healthcare why don't they come out and say it? The federal government controls the safety net and all the outpatient safety net provisions so that people that are disadvantaged or low socio-economic that can't afford to pay any fees, the federal government sets those outpatient Medicare gaps, which I think is up to around $1000 or $1200 for a family and less for an individual.

The bulk billing incentive - increasing the fee to $18 - is not getting near 50 per cent of the AMA fee and this is the complexity. So, we move, obviously, from the community healthcare - and the final thing about community healthcare is, patients often get seen in ED and if they don't need to be admitted, the plan is GP follow-up, which is a joke. Patients don't have a GP or they can't get in to see their GP for three weeks. How is that appropriate follow up? This is where the public health system actually has a disconnect between taking someone who has an acute medical condition, they temporise, they send them back to their GP, but there is no GP aftercare because they don't have a GP or they can't get in or they won't pay the bill.

CHAIR - What should be happening in that space?

Dr LUMSDEN-STEEL - Well, we need to ask the question, is it appropriate that the hospital can discharge back to someone without the resources to be followed up? If a patient doesn't have a GP, and honestly they are not going to pay for follow-up with the GP, what is their follow-up? I don't know. This is the question. Should the hospitals have more accountability when we discharge patients to make sure that they do get followed up? A GP, if they send somebody to the hospital system for elective surgery and there's delays in their care can be held accountable for the lack of that patient having care provided by the hospital system because the GP is the primary referrer to this. They are still under the care of the GP. The hospital doesn't seem to have the same accountability back on it. How we would ultimately solve that problem is actually by having more GPs, to be brutally honest, more GPs.

CHAIR - Which is is about federal government funding of the -

Dr BARRATT - One of the suggestions of the past was things like a voucher, so that for a patient who goes back to their GP, the hospital pays the gap. They can afford to go to the GP because the hospital pays the gap. It is certainly a lot cheaper than them coming back to ED. There is good evidence if they do come back to ED, people who are prematurely discharged, their reappearance rate is very high, is about 30 per cent.

Dr LUMSDEN-STEEL - It can be high, and often it's that management of that patient that may borderline developing a condition that is appropriate to treat conservatively, watch and wait, but then again, if you don't get back to see a GP to see how you are going or follow-up on investigations, or if you do not have a GP, sending a GP letter is going nowhere. This is a care gap.

The next thing to move onto though is when we look at how patients navigate the healthcare system. We talk about the funding not being based on what we know it needs to do and also the projective work that we know we need to be done. There's insufficient capability within the THS, we know that.

The infrastructure, so we read about these grand master plans for 2050. It's bollocks. It is absolute kicking the problem down the road when we need this infrastructure actually open by 2035. One of the AMA's biggest calls is that all these plans for health infrastructure investment cannot be left unfunded sitting in the future. We need to get on and do it now. It needs to be open by 2035.

The health budget does not meet the demand. Healthcare funding, as you know, is becoming murkier and messier. The federal responsibility and state responsibility, as you heard from Annette and as you know, the state is investing more and more into supporting primary healthcare because the GP services are unsustainable. Then we get this, the Tasmanian healthcare service and healthcare system, we are splitting our funds between literally our hospitals and having to keep GP clinics open. We have to do both, but again, it's a funding shortfall.

And as I was trying to get to, we need to understand the total system. So, we've talked about the community, the primary healthcare, and within the community you can see physicians and other specialists too. We talk about aged care. We talk about private and public and then within that we also talk about mental health. We've also seen how the unexpected and sudden closure of one can suddenly put stress on another. We've seen recent examples of that whereby services that have been closed, primarily for financial reasons or business reasons, suddenly mean that those services need to be provided by a public system that is not set up to do so.

Some examples of recent stresses are the Calvary Hospital Emergency Department not being able to remain open, so they close that. Then they were only open on Monday to Friday, and they're still not open on weekends. That means patients who would normally be able to go to a private ED end up coming to the public ED. It's only a small blow, but it's a burden of care that gets pushed back into the public. We saw the mother-baby unit at St Helen's Hospital being closed, and the public was not set up to take it and did not have the capacity. But it's also the staff who had that care plan and that history of providing that care, where did they go?

CHAIR - Where did they go? Where are they now?

Dr LUMSDEN-STEEL - Exactly. Then we talk about the district hospitals, about how the district hospitals have that capacity, and if we lose key GPs who are keeping them open, what happens? Mental health, we see the impact that happens on mental health whereby we have beds or don't have beds. That's one of our mainstays of keeping people out of hospitals and keeping them well is access to rapid mental health when you need to.

Cause of transfers and delays. Now, I'm sure you are aware of all of this, but I guess it comes down, the first thing is, a lack of an inpatient bed. But, a bed's not just a bed, as you know. To provide a bed is a whole structure that comes around it. There's the physical space, there's the nursing staff. As you know, we have nursing staff appropriately rostered with an appropriate load. We have the Allied Health staff, the social workers, the physios, the pharmacists, the dieticians, the speech pathologists. You've got the beds being turned around,

if a bed becomes available, how does that quickly get cleaned and turned around for the next patient to come into?

CHAIR - Are you talking theoretically or are you talking that this is what needs to happen?

Dr LUMSDEN-STEEL - No, the actual. These are the shortages.

CHAIR - You are talking about these as shortages, not as the things that exist?

Dr LUMSDEN-STEEL - These are not theoretical now. Correct. If you ask all of those services, they will tell you that they are really under the pump, and many of these craft groups we don't train in Tasmania. They have to train interstate and come back.

CHAIR - Sorry to interrupt, but many of those things that you're talking about, the sufficient staff to open beds and the lack of discharge processes on weekends and underutilisation of transit lounge, and the unavailability of staff to open beds outside of normal working hours, these are all things which exist, if you like, as functional components of the system but are being underused at the moment, would you say, because of a lack of resourcing?

Dr LUMSDEN-STEEL - Correct.

CHAIR - So if we had more staff on beds every single day, if we had discharge processes that were open 24/7, and if we had transit lounges that function for the same period of time, we would move people through the system faster, all other things being equal?

Dr LUMSDEN-STEEL - We can do. But I think it's unrealistic to expect patients to be discharged after 10 or 11 o'clock at night, because there's often no resources going home and who they are going home to. One of the critical things is that it's really romantic to think that we can discharge patients seven days a week, but the reality is there are no community resources available on a Saturday and a Sunday. If you're discharging someone who needs to go home with help, what other community resources are available? Because we're so short-staffed, nursing staff, physios, social workers, Allied Health carers that can provide that assistance, that if you're going to send someone home after hours on a Saturday or Sunday, who is going to provide that assistance as they go home? Because most people work Monday to Friday.

The other elephant in the room when you look at the community resources and the biggest gap created in resources has been NDIS. Effectively, I look at NDIS as almost paying AMA rates to healthcare workers and social workers and other workers. The business has been pivoting towards NDIS customers because it actually is great: we're providing services to those who didn't have it. But it's created a gap in services available to actually help facilitate discharging patients.

Just within the hospital, having a physiotherapist come and clear you and help you with your rehab, that delays you potentially going home, it delays the time you might be discharged. Social workers play a critical role in really digging into what the social supports are when you go home and recommending what you might need to go home.

CHAIR - Do you not think those services - Allied Health Services - should be available on the weekends?

Dr BARRATT - They definitely should be.

Dr LUMSDEN-STEEL - Absolutely they should be available on a weekend, but again you have to have enough social workers to provide a service and still have their time off.

CHAIR - So that's a separate issue?

Dr LUMSDEN-STEEL - Correct, I agree, so there should be resources.

Dr BARRATT - Double up in numbers.

CHAIR - At the moment, if you want to have discharge on a Monday morning then arguably some of that stuff needs to have been on Saturday and Sunday, otherwise they might end up leaving on Wednesday when they could leave on Monday?

Dr LUMSDEN-STEEL - One hundred per cent.

Dr BARRATT - Another thing we mentioned there is that the Hospital in the Home programs need to be expanded so that -

CHAIR - Up to 100 beds, you said.

Dr BARRATT - so that people can go home on a Sunday, with a bubble, which is what the hospital or home is; if it's properly resourced and properly expanded so it doesn't just exist 30 minutes from Glenorchy. It's got to actually go out into the country, it's got to go out into rural areas so that people can go home wrapped in that bubble.

CHAIR - Have you had conversations with the Government about funding Hospital in the Home and increasing it?

Dr BARRATT - Yes.

CHAIR - As you said in your submission, it's kind of a very lethargic take-off.

Dr BARRATT - It's something we've spoken about with them repeatedly, over the years.

CHAIR - What have they said are the blockages?

Dr BARRATT - It's funding.

CHAIR - Lack of resources?

Dr BARRATT - Lack of resourcing, a lack of nurses, and appropriate level nurses to run it. This is something that needs nurse practitioners to do the Hospital in the Home component correctly. You need someone who's decision-making capable to keep someone in their home.

CHAIR - Is it the AMA's view that work being done to recruit the nurses to be able to do that, to deal with the blockages with nurse practitioners?

Dr BARRATT - It's certainly not been a high enough priority in our point of view and our point of view for it to be bought up there, because yes, it does work well. We know the ComRRS system, which is the community rapid response service which is the other side of Hospital in the Home, which is what the GPs initiate to prevent someone coming to ED, works brilliantly. It's been rolled out across Launceston initially, then Hobart and then the north-west coast. Again, it only goes to nine at night, it's only within 30 minutes of the city centre. So, while it works well, it's limited. The Hospital in the Home is utilising the same staff, but you suddenly get the same staff doing twice the work - both brilliantly - but you should have twice the staff to do two jobs and not the same staff.

CHAIR - Yes, right, back to your statement.

Dr LUMSDEN-STEEL - The work's not getting any less complex, and that's the same thing. Obviously, the other cause of delays and transfers is delays to diagnostic work up investigations. The challenge we have is most of our public hospitals - the north-west, the north and at Hobart in the Royal - the inpatient is also competing with the outpatient investigations. So, patients being discharged need to have their ultrasound done, or their cardiac echo, their C2, their MRI or their x-ray. What we don't have is outpatient medical imaging resources that are set up at the moment. So, you need to de-conflict inpatient work - which is the emergency stuff and the acute stuff - because that can have delays being done because you've got booked cases and vice versa, outpatient stuff that's booked can be delayed because of the emergency work.

So, we need to be able to pivot and try to separate emergency from elective or outpatient, non-urgent stuff, because they're both competing with inadequate resources and that causes delays. We know that one of the delays for patients leaving hospitals is that they are waiting for an investigation. Sometimes you can be in hospital for two, three days or more because that investigation will determine your treatment, which will determine your discharge pathway. Sometimes, you could possibly think to discharge someone, but then if it takes you two to three weeks or four weeks to get that investigation when they go home, that's seen to be an unacceptable risk to discharge them home without that condition being treated. So, we know that what holds patients back in hospital is delays in getting diagnostic investigations being done.

CHAIR - Is that delay in the clinical investigation because there is not a medical specialist available to do that work on a weekend?

Dr LUMSDEN-STEEL - Partly; no, not so much, I'll go to obviously the screen, sorry, but it's not just the medical specialists to report investigation, but often it's the sonographer, the allied health-trained person who is the sonographer who will actually do the ultrasound; it's the availability of the CT scanner and people to keep it running. If you want to get an MRI scan or CT scan, there's only so many scans a machine can do during a day. If you are continually interrupting booked scans for emergency scans - which could occur - that pushes people or delays investigations. So, it's not just doctors; it's the radiology staff who provide that service and it's having the physical equipment to do it.

CHAIR - I understand why the people don't want to work on the weekends, but we do have seven days a week care needs for people in hospitals and there's obviously blockages. Is this something that's happening in other states, where people are working on weekends - allied health and others?

Dr LUMSDEN-STEEL - We do have capacity, albeit reduced on a weekend, and allied health do work. But again, if you've got more staff, you can get more through in-hours. I mean, lot of the stuff we can do and the outpatient elective stuff could be done at an offsite, elective location whereby from Monday to Friday and every Saturday between 8 and 6 you can rock up and get that non-urgent investigation. It's still to be done within days to weeks or within weeks to months; and then that frees up capacity in the public health system because you've got less of that outpatient non-urgent stuff. It still has to be done, when I say not urgent, it is not life critical.

CHAIR - They are not holding up a bed.

Dr LUMSDEN-STEEL - Correct, but then we have patients holding up beds because they are waiting for that scan.

CHAIR - Anita, you've got a question?

Ms DOW - Thank you. I wanted to take you both back to infrastructure and you spoke about the need for the investment now and not pushed down into the outyears which what we're seeing with a number of the large health infrastructure projects. If you could prioritise two of those health projects to be fast-tracked, what would they be?

Dr BARRATT - I would certainly talk about the St John's Park and the sub-acute beds which they have put out there for both mental health and physical. Both the eating disorders, the sub-acute stays, the new palliative care service - everything that's going up at St John's Park would be my preference. Which then allows things to be decanted from the Royal, which includes the mental health - which is a whole floor in K Block - all to be decanted out to a good service in St John's Park, which allows more space in the hospital. It's a really good plan. I have actually seen the St John's master plan, it's a good plan - but 2050, I am going to be 92, so I'm not exactly going to see it, and that's a bit sad.

Dr LUMSDEN-STEEL - You'd have to say St John's Park, and I think we've missed the opportunity there too. We talked about outpatient investigations. Mental health definitely needs to be in an appropriate site and, again, the adolescent care and other areas too. And rehab - do we talk about rehab? Which we haven't really got to yet?

Also, Tasmania's unique. All our major hospitals all have emergency departments for the public so we do not have any public elective operating or procedural locations. But what we've done is outsourced: 45 per cent of elective surgery in the Royal has gone to private. We've sent it to Calvary, to Hobart Private, to Hobart Day Surgery, to the other spaces where we can get endoscopy done, surgery done, et cetera. And I know: I work in private and I do public patients in private.

St John's Park, if it's done well, it's probably in an appropriate corridor. Yes, there'll be logistical issues around getting facilities up there, but yes, it's an option to maximise and decant some of that work from the Royal that we should be putting out somewhere. The other

infrastructure would be: how do we look at the equivalent up north? How do we have the sub-acute beds up the north, because what we are seeing is the Launceston General Hospital is in crisis.

They have an absolute bed crisis. The Royal, we built that temporary demountable ward system above the old Emergency Department, the J Block, you have probably all seen it. That has been there now for what, 10 or 12 years? It was supposed to be a temporary two to three years while we're doing some redevelopment work. There's no way we can close that down. Launceston has suffered terribly by that emergency department not being able to get patients out of that ED. We've heard time and time again, unfortunately, of patient suffering and issues in Launceston. Even if patients are on a palliative pathway, we can provide them much better care by getting them into the hospital, having them in a safe, appropriate environment. If we can do something the ambulance brings it to them, we get them in the Emergency Department, it's well staffed, what do we do? We do what we do in the Emergency Department, then they go to the ward. At the moment when you are stuck in the ambulance and you're stuck in the ED, you're not getting the next stage of care that you need to get.

This is moral injury burn out that I know you have heard from nursing staff and other staff in ED that actually leads to people leaving the health service, and we can't recruit, attract and replace those people.

CHAIR - As anaesthetists and general practitioners?

Dr BARRATT - All across the board. We are getting moral burn out. One of my other hats I wear is as the Medical Director of Doctors for Doctors, which is the doctor's counselling service. We are being rung continually by doctors telling us that they've come to the end of their tether. They are just tired and tired of hitting their head on a brick wall, watching patients suffer and not being able to do the job for which they trained.

None of us go into medicine for money. Certainly, those of us who went to general practice didn't. We into it because we want to care for people. If we can't care for people, it destroys the person doing that caring. The moral injury is happening. It's all around. When I speak to my colleagues in the similar medical director's roles across the country, we are seeing it everywhere. Tasmania is seeing it a lot worse than other places.

CHAIR - To be clear, it is not just general practitioners who are feeling this because everyone, as you and Michael have laid out, it's people, medical specialists and medical staff, all the way through the system.

Dr BARRATT - All the way through. I'm talking to junior doctors in their first and second year, so that undifferentiated in their training who are looking to get out of medicine. So, two to three years out of medical school after they've built up a $160 000 HECS debt, have got to the stage of saying, 'Nah, don't want to do this - can't do this'. And that's sad.

Dr LUMSDEN-STEEL - Obviously, we're talking about doctors here but our Tasmanian health service is that critical location that provides for most of our healthcare workers in Tasmania, that postgraduate training. You go through nursing school or medical school or whatever degree you have done, and then you are employed in our service. Obviously, we've got the private hospitals too.

But before I forget though, just getting back to Launceston, the other issue about access to beds and care in Launceston is they don't have a functioning private emergency department, as you know. It is all the public system. We talk about priorities for growing the health service and helping to address access block. The other critical investment would be getting that co-located private hospital in Launceston because even if you had one ED because you can't sustain a private ED, you have the option and hopefully the capacity to decant patients into that private hospital by the ED. So, instead of having to be bed-blocked in the public hospital, you have the option - if you choose and you've got private health insurance - and there's also the workforce, which is the doctors and nursing staff, to be diverted from public to private.

We talked about the infrastructure, and the point where that goes is it's understanding that public and private should work together, which gets to how we collaborate. When we understand what the statewide and area demand is, how does the public and private talk and plan and support each other? If the Government's going to go into arrangements to manage public hospital demand, for example, outsourcing elective surgery, it's having, obviously, good value for money, appropriate expenditure of public money and appropriate expenses. It's having appropriate contracts that allow the private sector to provide that resource and not just solve a problem in a three-month window because there's a short bucket of money that's got to be spent or it goes away.

The long-term goal for that money that's being spent in private to temporarily manage a problem, should long term coming back to the public system so that you increase public capacity, or - and it's not uncommon in some states that they've just accepted that we're going to have an ongoing 10 to 20 per cent of surgery being done in private because we'll never have the capacity.

The key point here though is that every time we outsource work to private we often outsource the fit and healthy patients because they are the easy, cherry-picked, they're going to be in hospital for a day or overnight; they're not going to require all the other high-complex care needs. What we've seen has happened there is that the public healthcare system is managing and having to deal with the complex patients that require more support. They're in hospital for longer, they occupy a bed for longer, this is just the facts that means that because they occupy a bed for longer, there is less surgical-bed availability.

The challenge is that these are the patients who wait the longest for their surgery. They're lower in socio-economic status; they haven't got the private option because they can't pay for it, but they're waiting longer for their care. They're waiting longer for their care because they have to have the public hospital bed; they have to have the HTU bed or the ICU critical care support. And they're the patients who suffer the most because we don't have the public hospital capacity. The fit, healthy patients are often the ones being outsourced who get their surgery much quicker. They are often waiting months for their surgery in private if they get outsourced, as opposed to 18 months, two years for that complex patient because they're waiting for the public hospital resources.

CHAIR - The public health capacity, which you talked about before, and St Johns Park was one example you gave, that needs to be built by 2035. The AMA must have reflected those concerns to the Government. What was their response?

Dr LUMSDEN-STEEL - The brutal issue is that this is all levels of government that come back and say, 'Why do we keep making these projections so far in advance when the need

is now?'. Again, one of the single most important things we need to do is have an actual accountability for what the demand is and what the service needs to be and, from that, what we need to do to provide that, which is locations, and a workforce, and a care plan, and that needs funding. What we see is a government has a bucket of money; the bucket of money is what they've got to spend, and then they've got to divide it up. We don't think you can take money from everywhere else the Government is spending. Where can you take money from to put into health care anymore? You probably can't. We're spending what? A third of government expenditure at the moment is going to health care, if not more.

CHAIR - When you are talking about building a new piece of infrastructure, that is not in the recurrent budget. That is a separate, you know, that -

Dr LUMSDEN-STEEL - It is, but you have to staff it. The staffing becomes a recurrent budget. So, we can kick something down the line, in terms of saying, that's going to be a - I will just throw a figure there - a $1 billion entire development plan for the physical infrastructure at St Johns Park, wherever it's going to be, but then you have to staff it and that's the recurrent funding.

Dr BARRATT - The other thing we did suggest to the state Government is that they push the 50/50 funding from the federal government as compared to the current 45/55, because it was 50/50 during COVID-19 and then, of course, it reverted. We have been talking to the Government about pushing that. That extra 5 per cent in this state -

CHAIR - Why wouldn't they be pushing that?

Dr LUMSDEN-STEEL - Well, I think we are, but the problem is that there's two parts to that. The feds determine this, so where are the federal politicians? What's their interest and where are our state and federal politicians at the moment? What are they doing about this problem? Why aren't they lobbying Canberra. The key thing is, as you know, there's the funding arrangement, the 45/55 which we are going back to, I believe, or we are back at -

Dr BARRATT - We are back at.

Dr LUMSDEN-STEEL - but also, there's an activity-based funding cap. So, even if the state said, 'We're going to put an extra billion dollars into health care', the feds aren't going to match that under the current arrangements because there's a funding cap increase of 6.6 per cent per year. If, say, for whatever reason, the state got an extra billion dollars a year to put into health care, it still wouldn't be matched by federal government funding. So they're not getting as much bang for their buck once they go over that activity-based funding cap.

To be brutally honest, if you went back and looked at what happened over the last 20 to 30 years of the Tasmanian spending in health, every year that we did not increase our funding meant that - and we increased the gap in what we had to provide versus what we could provide. What we've never done is have that community-based funding leap back up to what it should be. All we've seen is rescue buckets of money which are defined for a short window to deal with an outpatient problem, or a short problem, but it is no sustainable funding increase.

Dr BARRATT - If we are looking at the health care - we've mentioned in our submission that it doesn't just deal on health care. We need to be talking about education. We need to be talking about housing. There are so many things that improve the wellbeing of the Tasmanian

population which takes the demand off health care, which are long-term, but they are also factors that affect ramping.

CHAIR - They ddefinitely do, that's right. I'm really sorry, we could keep asking questions all afternoon. You've so much to say. I want to thank you for the quality of your submission. It's very detailed. It has a lot material in here for the committee to use in our report. Thank you for your quality work.

Before you go, I need to remind you about what I said at the beginning that everything today is protected by parliamentary privilege. When you leave the room, you need to remember that the privilege doesn't follow you if you make comments to anyone outside, including the media, even if it's just repeating what you said here today. Is that clear?

Dr BARRATT - That is clear. Thank you.

Dr LUMSDEN-STEEL - Yes. Thank you.

CHAIR - Thank you so much, Michael and Annette. Thank you. We can stop the recording.

THE WITNESSES WITHDREW.

The committee suspended from 4.03 p.m. to 4.04 p.m.

CHAIR - Welcome. Have you all read the information that the secretary sent about parliamentary privilege? This committee is a hearing of parliament. It is covered by parliamentary privilege. That is a legal protection that allows you to give evidence to this committee without fear and in the freedom of not being sued or asked questions in a court or in a place outside parliament, so this parliament can get the best information from its inquiries.

You need to recognise that protection does not follow you outside of this room, even if you are referring to comments you have made here today. This is a public hearing which is being broadcast and your evidence could be reported. If there is anything you want to say you want to be private we can go in camera if you let us know and give an explanation for that. Do you understand all of that?

WITNESSES - Yes.

Dr STUART WALKER, SURGEON, **Dr JANE TOLMAN,** GERIATRICIAN, AND **Ms JEANETTE PALMER,** REGISTERED NURSE, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you so much for coming. We've read your submission. It's very detailed and we thank you for that. Would you like to start with any opening words or a statement?

Dr WALKER - What I thought we might do, then, is that if the three of us, individually, give you some indication as to why we're here and are interested in this problem. As I seem to have the floor, if I start with mine, is that all right?

CHAIR - Thanks, Stuart.

Dr WALKER - As I said, my name is Stuart Walker and I've been a staff specialist in vascular surgery at the Royal Hobart Hospital for more than 20 years now. I've previously been the Clinical Director of Surgery at the Royal, and I've held a number of committee positions, mainly related to patient safety. Currently, on behalf of the Death Review Committee at the Royal Hobart Hospital, I review every death in the state. The principle reason for doing that is to try to identify those who have been treated at the Royal Hobart Hospital where there may have been a systems issue surrounding their death.

I have been struck by the number of elderly patients sent by the community to the Royal Hobart Hospital, but also other public hospitals, where they have been sent to that facility, in essence, to die. Or, where they've had a non-life-threatening condition which could have been managed in their own residence. This issue of access block and delays in transfer of care impacts upon my ability to do my work, as my patients are frequently postponed from having their surgical procedures due to a lack of inpatient beds.

I'm also troubled when I am the on-call vascular surgeon for the State of Tasmania and there are patients, particularly in the north and the north-west of the state, who are awaiting transfer to the Royal Hobart Hospital and we cannot get them down because of a lack of bed space. Patients can wait for days, and maybe even a week for transfer down, and that clearly has an impact on their subsequent outcomes.

CHAIR - Yes, absolutely. Jeanette?

Ms PALMER - I am Jeanette Palmer and I have been an RN working in the aged care sector for 35 years plus. I've worked in both the north and the south of Tasmania, as well as Queensland. I've come here today because I see many issues with resident admissions to the facility from hospital. This includes both new admissions, as well as resident returning following an acute event or an exacerbation of chronic long-term conditions.

CHAIR - Did you want to say anything, Jane?

Dr TOLMAN - I've just done some sums: between us we have 99 years of medical experience.

CHAIR - Wow. That's exceptional.

Dr TOLMAN - Stuart and I happen to have been interns the same year in different places. My background is that I have been a doctor for 33 years and I have worked in regional and metropolitan Sydney, New South Wales. I have been in every single nursing home in Tasmania, and for six glorious years I was the Director of Aged Care at the Royal Hobart Hospital. Currently, since 2014, I have worked in private. I am a community geriatrician. I see patients on referral from their general practitioners only. I bulk bill everybody. I spend a lot of time working out what is going on and getting a plan. I have very strong feelings about what the problems are and what we need to do about it.

Stuart and I have read through most of the submissions that you have had. For me, they break up into two rough groups: the poor hapless patients who've had a hard time of it, and some of those are absolutely heartbreaking; and then there are the health professionals who, effectively, are mostly saying we need more money and more staff. We take a very different view. When you want me to I will tell you the perspective that I have as a geriatrician working with colleagues. We haven't been particularly friends, but we have a community of interest and we felt that it was important to get the message to you.

CHAIR - Thank you, James, Stuart and Janette. You have given us a lot of detailed information about the poor discharge planning that exists and some really fantastic, very clear ideas about how it could be improved, so I think we should focus on that.

First of all, you also talked about the lack of staff trust in hospital management. I wonder if you could outline for us how you think that has happened and why it matters?

Ms PALMER - Yes, I believe it's due to a lack of continuity of care in the hospital. The information that we get is often misrepresenting the resident's actual care needs. We could have somebody coming back that the discharge plan - if we get it; usually it's after the event - says one thing, but when we do an assessment there's obviously other things impacting on that. Residents coming back who are deconditioned is a common event. Residents coming back without any long-term goals of care.

Now, as you are probably aware, dementia is a terminal, progressive illness. It doesn't get better. Families don't recognise that, so there's obviously been no consultation with the families to plan the future care needs: where to from here. If that was in order then it would decrease the amounts of returns to the hospital. If the medications came with the resident: the detailed plans and things like that, the appropriate medications. We've had residents come back that are palliative without any comfort medications, things like that, which have a huge impact.

We do not have doctors in the facility 24/7. That makes it very complex for us. If we can't manage somebody's pain, we're not going to keep them in the nursing home. They will have to go back to the hospital.

CHAIR - Did you want to say anything about trust in hospital management, either of you? No?

Can we just talk about some of the things you suggested in discharge management? You point to a number of things. One of which is not having ACAT assessments done in a timely manner. You made a comment that there are associate ACAT assessors in the hospital. This is news to me. I didn't understand that was the case. Could you talk about that? Is that one hospital, is that all the hospitals?

Dr TOLMAN - I'll talk about that, because I actually set that system up. I would like to go back further than that, though if I may.

On 28 December 1989, I did my first day as an intern at Prince Henry Hospital in Sydney. We'd all been called in a week early because of the Newcastle earthquake which happened on that day. It was a crisis. On 13 July 1999, there was a story in the *Sydney Morning Herald* with four senior clinicians including Dr Jane Tolman, who was the current clinical superintendent at the Prince of Wales Hospital, looking very stern and talking about the lack of funding in the New South Wales health system.

Both of those have been so long gone and I happily say that I agree with our AMA colleagues - Stuart and I are both members of the AMA - that Tasmania is a total basket case. I don't work in the hospital anymore. I know what is going on in the hospital because people tell me.

What I'd like to share with you is my take on why we are in this situation and hence what we can do about it.

The details about the AMA - that's a detail. In 1990, when we became interns, hospitals were all about acute episodes of care. I seemed to have spent half my time putting drips in people with acute asthma attacks or getting people ready for gall bladder surgery. That's what it was about. This many years later, that is not what hospitals are about. I don't know the numbers anymore but what hospitals are all about now is about old people falling over and injuring themselves. They're about old people going into a delirium, becoming confused, with simple things like a urinary infection.

I don't know what the length of stay was 33 years ago, but I do know that families I see now tell me that their mother's been in hospital for four months or six months. I had a patient recently who'd been in hospital for 16 months.

CHAIR - Yes, I heard that from someone else. Wow.

Dr TOLMAN - Now, why that is, is very important and complex. There is no simple reason, but here is my take on the reason. When we started our illustrious careers, the reasons that people died were mainly vascular diseases: heart attacks and strokes and cancers. In 1906, Professor Alzheimer identified the first case of Alzheimer's disease. We are living in the 21st century, which is the era of neurodegeneration. We are living long enough to get a whole

new range of diseases. Those diseases, 90 per cent of the time, are dementia. The rules that applied in 1990 no longer apply. If you think that bringing everybody into hospital and doing tests, finding out the problem and treating the problem - that's not how things work anymore.

So, here's the go. An old person presenting to hospital is going to have one of four outcomes. That doesn't sound like rocket science, but in order to work this out, you need to follow the rules of the 21st century, the century of neurodegeneration. So, what will happen to an old person in hospital?

One: the person may have an acute illness which can be cured. That happens. Might be pneumonia.

CHAIR - Yes. Maybe an infection or something.

Dr TOLMAN - Second: it may be that the person has reached the end of the road. Now, that might be because they've got congestive cardiac failure or because they have dementia or because they have severe airways disease. Dementia is a relentlessly progressive, terminal disease and is the leading cause of death among Australian women today. In three or four years it is going to be the leading cause of death overall. Now, this is not a hospital that identifies that dementia is a relentlessly progressive terminal disease and until it is, they're not going to deal with those people.

So, we've the cured people. We've got the palliated people - keep them comfortable and allow them to die with dignity, that can be in an acute hospital, it could be back in the nursing home, it might be in their own home with the wonderful community supports we have, it might be in the Whittle Ward or St John's.

The third thing that might happen is they might be rehabilitatable. That is why we have rehabilitation wards.

The fourth possibility is that the person needs a nursing home.

CHAIR - So, they don't have dementia, necessarily?

Dr TOLMAN - They've got dementia, almost certainly.

CHAIR - But they're not at the point where they need to be in the Whittle Ward.

Dr TOLMAN - They don't need to be in the hospital. The people that I see now have been in hospital for four months. We had one recently who had been in hospital for over a year. I had had a referral to see that person at home, rang up to say to the family can I make an appointment and she said, 'I am sorry, she has gone to hospital'. Sixteen months later, around about, she's in the nursing home. Now, what was that all about? I will tell you why. Here's what should be the model of care. Am I going on too much?

Dr WALKER - Keep going.

Dr TOLMAN - The model of care should be when the person comes into the hospital, the family is brought in too.

CHAIR - Right. Okay.

Dr TOLMAN - The era of neurodegeneration is mostly dementia and if you do not get the story from the family or the loved one, you do not know what is going on.

CHAIR - And if you do not reciprocally have the story with the family, then they don't know what the progress is going to be. They don't know where things are going.

Dr TOLMAN - Absolutely.

CHAIR - They do not get to have the conversation.

Dr TOLMAN - That's another side of the story, that absolutely is, and that's the complaint that I hear every day. So, there needs to be an early family conference. At that family conference it is usually possible to identify the goal of care.

So, this is the example. The daughter says, 'I promised mum she's never going to have to go to a nursing home'. Now, many of the doctors in the hospital would say, 'Oh, the family doesn't want a nursing home', so, the person will stay in hospital for six months, trying to work out what to do. Whereas an experienced geriatrician might say to the daughter, 'Tell me what has been going on, what is happening?' At the end of it I say to the daughter, 'Do you really think you are going to be able to keep going?' And the daughter starts crying, 'No, Dr Tolman, I don't'. An early family meeting, with the establishment of the goal of care, easy. One of four things. It's not rocket science. And then a daily multidisciplinary team meeting. Now, if you don't have input from your social workers, your occupational therapists, your speech therapists, all of those people, you can't really get a clear sense of where you're headed.

CHAIR - So, do you think these things, this care team, family conference with the patient, should be happening in the hospital setting?

Dr WALKER - Within 24 hours of admission this should be happening, so that you can give the patient, their carers, their relatives, a clear expectation of what's going to happen. As you've already heard, diagnosing dementia is not just using some score on a piece of paper. You've got to hear the story from the family. This is why you need experienced geriatricians to help establish that diagnosis and start to use the family to make a clear plan going forward.

Dr TOLMAN - I bet what you have not heard during your inquiry is the way the hospital works now. In 2011, when I set up the state's first acute aged care ward, which doesn't work like that anymore because I haven't been there for a long time, every family had a family conference on day one or day two, a multidisciplinary team meeting every day, and every person was followed through by the consultant who was on the ward every day. The length of stay was less than a week.

CHAIR - This is for the same sorts of patients with dementia?

Dr TOLMAN - They're the same patients. I said to my colleague, 'Should I bring the thank you book?' The thank you book filled with cards and death notices and letters expressing gratitude for the way their parents, their families had been treated. What happens now - Simon, you're new in this field, have you got any sense of how the hospital works? If your dad or your mum goes into hospital, what do you think's going to happen?

Mr BEHRAKIS - As you said I am new to this job, but -

Dr TOLMAN - You're new. Well, let me tell you what would happen. What would happen is that nobody would talk with you. Every Monday the medical team changes over.

CHAIR - Right. Every Monday morning for the week?

Dr TOLMAN - For the week. So, every Monday is a different team.

CHAIR - Why is that?

Dr TOLMAN - Well, you tell me. Every Friday I might ring up, and if I am really lucky, the person I speak with won't say, 'Oh, we can't talk with you because you don't work in the hospital', very common. If I can find somebody who'll talk to me, they will almost likely say, 'I am not looking after her on Monday so I can't really tell you anything'. If I ring on Monday, they'll say, 'I haven't met her yet, don't really know'.

Mr BEHRAKIS - There is no continuity.

Dr TOLMAN - There's no continuity. How could there be any appropriate model of care for somebody who is confused and mixed up when the doctors change over all the time?

CHAIR - Are you talking now about people who have been admitted patients? People are coming into the emergency department, elderly people are coming in and they'll be in one of those four categories you are talking about. But if they've got dementia, for example, if they come in with a diagnosis or could potentially, I suppose, get a preliminary suggestive diagnosis there.

Dr TOLMAN - As my learned surgical colleague says, you can't diagnose dementia based on a pen and paper test. There are many people who perform quite well in a pen and paper test, but don't even know if they're in the supermarket or their own home. Unless you get the story from the family, you can't diagnose dementia. It's the failure to diagnose dementia, to work out who is the decision maker, to do a capacity assessment - these are the reasons the hospital doesn't work. These are the reasons that we hear, because there is no prospect of recuperation for this health system.

CHAIR - How should that be happening in the hospital? Where should that be? You've mentioned somewhere - I think - in your submission, you think there's 13 geriatricians at the moment in the Royal Hobart Hospital -

Dr TOLMAN - Rosalie, it's been done. Look back, we had an addition - the Newnham and Hills Report. If their recommendations were carried out, we wouldn't have a problem. My personal perspective, as somebody who's been trying to make this health system work since I set foot in Tasmania on 13 June 2006, is that until the parties stop using health as a political football and start saying, 'Okay, these are the problems. Newnham and Hills identified the problems. Dr Tolman is just reinforcing what they said. We know what needs to be done'; it's been said time and time again. Why do we need you? You're here; have a look at that. It's all there for you. The doctors are not going to want to do it. You've heard the doctors talk. The doctors think it's about more money, more resources, more beds.

CHAIR - Can I talk about why the doctors don't want to do it?

Dr TOLMAN - Well, because it's a culture change.

CHAIR - When you say the doctors, who do you mean?

Dr TOLMAN - I'm talking about - not all of the doctors. Some are my best friends -

CHAIR - Are you talking about geriatricians.

Dr TOLMAN - I'm talking about geriatricians. You don't know my history, presumably. Google Dr Jane Tolman and you will see what happened to people who tried to make change. We put in there Prof Haydn Walters' article about the toxic culture at the Royal Hobart Hospital. Simon, you should read that. I know you can't read everything; but if you want to know what we need to do, look at that.

CHAIR - This is coming back to me, as you are talking now, yes.

Dr TOLMAN - We are in privilege now - this can be reported, can it?

CHAIR - It is being livestreamed but you have the privilege of parliament with what you say here.

Dr TOLMAN - I ran into a previous premier of this state when I was leaving the Health department. I apologised to him that it was costing the Health department so much money not to have me in the health system anymore. He said, 'Jane, nobody's going to take on these doctors'. And nobody is going to take on these doctors. It's not all the doctors.

There are some fantastic doctors. There are people who work day in and day out. But, that moral injury that people talk about, what we need is a system that is devoted to the welfare of the patient; not 'what can you do for us doctors'. Patient-centred care is what this is all about. Patient-centred care means that we look at what do we do to fix up this person, this person's family, this community. When we're all working together for the benefit of the patient, the community, we're also working for the benefit of the hospital.

CHAIR - This report, the Newnham and Hills Report, was about the Royal Hobart Hospital. Do you think the findings and recommendations in it would apply just as much to the other hospitals across Tasmania?

Dr WALKER - Almost certainly so. In my capacity as a vascular surgeon, within my department we provide a statewide service. I do a clinic every four weeks in the north-west of the state and at the Launceston General, so I actually work in all regions of the THS. There's no great difference between them. They all suffer with the same problems and they all suffer, as you know, with the issue with bed-block, ramping, et cetera, so it's across the state.

CHAIR - Can you talk a bit more about how Allied Health can work in this area and what some of the deficiencies are with the current situation with Allied Health support helping with discharge and helping in the hospital setting?

Dr WALKER - Well, I think one of the things that you just heard from the AMA is a recurring issue and that is that they work a definite Monday to Friday, 9 to 5 roster, if that's what you want to call it. There's nobody around late on a Friday night or over the weekend. For example, we will not uncommonly have patients on Thursday. We've decided that the patient is probably good to go home and then somebody from Allied Health will come along on Friday, make an assessment of the patient and not agree with our thoughts and say, 'No, the patient needs to stay for a bit longer, and I'm off for the weekend now', and then we're stuck. We're stuck with the patient now until at least Monday because there's nobody on allied health to actually come and do whatever it was that was impeding the discharge.

So, there's an issue with getting appropriate things like physiotherapy, speech therapy, and even social workers to come and engage and help us get the patients through the system after hours, but especially at the weekend.

You made the comment, I think, during the AMA's presentation, 'Nobody like working weekends'. I don't like working weekends. But, unfortunately, health doesn't occur Monday to Friday, 9 to 5. That's why there needs to be a change in the way that we provide our health service, not only the doctors, but the nurses do it, you know, they do night duties et cetera; but the Allied Health need to come to the party too. I am sure they would do if they were -

CHAIR - I'm sure they would if they were paid appropriately for working on the weekends.

Dr WALKER - Correct.

CHAIR - Many people work on the weekends, and choose to do that if they're paid appropriately. Anita?

Ms DOW - Thank you all for coming in and presenting to us. I just had a question about your submission where you make reference to having teams of geriatricians, nurse practitioners, Allied Health and admin staff. I wanted to know whether you thought - there's obviously nothing like that currently across the state. Would you see that would be good working across each of the regions of the state as a way of keeping people more well in the community and better supported in the community, like you put in your proposal?

Dr TOLMAN - There are things like that. Hospital in the Home is a fantastic service. Hospital in the Home is a very good service. The rapid response team is a very good service, they work together. The Community Health are very good, the Palliative Care are very good. Mental Health are going through a bit of a crisis at the moment but there are teams that go into the community. The Hospital in the Home team is about to have an extensive increase in its numbers.

But it's not about more people. It's about the philosophy of what are we trying to achieve. It's about working together for the benefit of the patients and the families, and listening to families. Listening to people. Making the appropriate diagnosis, getting a plan and carrying it out. You can make three shiny new hospitals. You can triple the number of staff. It won't make any difference.

Ms DOW - The point that I was trying to make was that if it's community-based and you apply that philosophy in the community around goals of care and family meetings and early

planning at the early onset of disease. If you had the resources in the community to do that, to work alongside community health and Hospital in the Home and you had that dedicated geriatrician role, I could see that there would be merit in that. Because you would not see people coming at crisis point to the hospital or having that work to be done in the hospital where they then remain for however many days as an inpatient, rather than being back in the community and well-supported or having a good plan around their care. I guess I wanted understand more about what you meant about that model and how you would like to see that rolled out across the state?

Dr WALKER - Can I just interrupt? I think one of things which has been a recurring thing that hopefully this committee is getting to, is there is a disconnect between many of the services. Particularly, in the space where we're talking there is a disconnect between, for example, acute health care geriatricians and community geriatricians, which seems mad. They should all be working as part of the same team, freely communicating within that team and freely communicating with other allied health professionals.

One the things that was, for example, raised by - I think - the Ambulance Tasmania presentation earlier was the fact that we don't have an integrated medical record. There is one example of where free communication could potentially be electronic, but we do not have the facilities to be able to do that. If you had the personnel working together as a team, who were able to freely communicate both verbally, in person, but also by having a unified health record so everybody's on the same page, there's a clear plan, what's going to happen with this patient when they do go home, how can we prevent the patient from bouncing straight back to the hospital? It would make so much of a difference.

CHAIR - Have you had any engagement with the digitising of health records - which the Government is undertaking a huge body of work in this space - have you been consulted about that?

Dr WALKER - Personally, no.

CHAIR - No? Okay, because obviously, that's one part of the story, isn't it, getting information which can be transferred without mistakes being made and travel with the patient more easily than it currently does.

Jeannette, you work in residential aged care, something that another person who made a comment to us was around the fact that there should be more heavy lifting done within residential aged care to not put people on ambulances to go to hospital to deal with things that ought to be being dealt with in residential aged care; and that that's something that should be happening at your end, not passing the buck. I am just reporting what the committee heard.

Ms PALMER - The issue with that is the fact that when a resident comes to us there's no goals of care mapped out. Families are led to believe that we can make them better with these chronic health conditions; and they're under the impression a lot of the time that, 'Right, if we send them back to the hospital they will get better'. If they had those discussions, and particularly, most of the residents have some form of dementia, and it is a terminal, progressive disease, they are not going to get better from this.

If they recognised that, then have the choices of which area, where to go, are we going to keep comfortable, if we've got an acute event, do we send back to the hospital. If we had

access more readily, access to ComRRS, then they could come and treat in the nursing home. We do palliation in the nursing home. As it is now, we can't get access to the community rapid response team.

CHAIR - When you say comms, do you mean community?

Ms PALMER - Yes, Rapid Response Team. Because we have to have a referral from a GP to them. We can't get access to GPs 24/7.

CHAIR - In your submission you make the point that rapid response teams should be expanded to cover the state, and that they do excellent work but there's just not enough of them.

Ms PALMER - There's not.

CHAIR - Can you talk about how much there exists of rapid response teams and where they're distributed across the state? If you know that?

Ms PALMER - If a resident has an infection - and particularly if they've a dementia or a delirium, or whatever - then their behaviours will escalate. They'll become septic very quickly, because most of them are, in some way, immunosuppressed. If we have access to these people to come in to give them IV antibiotics it stops it progressing. So we can treat them there, we can keep them comfortable and look after them so they do not need to go to the hospital.

CHAIR - And who funds the rapid response teams?

Ms PALMER - Well, that would be the hospital?

CHAIR - The State Government?

Ms PALMER - Yes.

CHAIR - Yes, so that would seem to be something which would be a good form of prevention.

Ms PALMER - Easily.

CHAIR - How long have they been functioning for? I am not aware of the history of the rapid response teams.

Ms PALMER - Since I have been here.

Dr TOLMAN - Three or four years.

CHAIR - Yes, okay.

Dr WALKER - Particularly, the Hospital in the Home has been a fantastic service, but the problem with the Hospital in the Home is that it's very localised geographically. Again, I think you've heard this earlier during the day, if you live in the Huon Valley or in the Derwent Valley, you cannot access the Hospital in the Home service. If that was to be expanded to

particularly some of those more regional areas, that would make a huge difference to the number of people who are unnecessarily sent to the emergency department.

CHAIR - What is the difference between Hospital in the Home and Rapid Response Teams? Hospital in the Home people get scheduled visits, do they? And a rapid response is obviously an acute event and people can be sent out?

Ms PALMER - For example, we had a resident that had a fall that had a skin tear that needed suturing. Rapid Response came in and sutured that person.

CHAIR - Who decides who gets rapid response availability and who doesn't?

Ms PALMER - We were fortunate, we could ring the GP to do the referral at that time. But, had it happened after hours or on a weekend, we would have been stymied, because that person would have had to go into the hospital.

Dr TOLMAN - If I can say, it all comes down to culture. I have a fantastic relationship with the rapid response and the Hospital in the Home, they work together. They are expanding and that's fantastic. But I have, on some occasions, wanted to refer but couldn't, because I'm a geriatrician, not a GP. And when there's somebody Jeanette needs to be seen and she can't get hold of the GP because he's busy, she can't make a referral either.

These rules come down to the culture; and the culture is, 'Well, we've got to protect us and make sure that we can manage everything', not what's the need out there. To criticise the nursing homes and say, 'Well, it's their fault, sending all these patients back to us', when they got the wrong story, and the families have got completely wrong ideas about what's going to happen.

CHAIR - So, when people come to residential aged care with dementia and families have incorrect information, where do you think that should be starting in Tasmania? Where should the conversation start? From the point of diagnosis, so the GP should initiate that?

Ms PALMER - The majority of our residents would come from the hospital.

CHAIR - So, they go to hospital and get diagnosed in the hospital?

Dr TOLMAN - Yes.

CHAIR - Yes. So, that goes back to what you were talking about before, Jane.

Dr TOLMAN - Well, they do not need to go to hospital to get a diagnosis, but should an old person fall over and hurt herself; should an old person become delirious with a urinary infection and go to hospital; at that very first family meeting, that's when you investigate the diagnosis. If it is dementia, you might say to the family, 'Look, has dementia been diagnosed? This is what it is looking like. This is what we need to do in order to find out'.

CHAIR - Would you support, then, a sort of statewide model that would, wherever a person got diagnosed with dementia - either through a GP or in the hospital or some other specialist - would be a standard response in terms of involving the family and having a certain range of information about what dementia means provided in that context? Set some minimum

standards, I suppose, to do with the diagnosis of dementia and a package that would be replicated across all services so that people are on an even playing field?

Dr TOLMAN - To prepare for today, I thought about something which I then forgot about; but you have said it all, really. There ought to be a bill of rights - and there probably is, and has been done many times - a bill of rights for somebody with dementia. If you've got cancer, nobody is going to not tell you or put you on the right journey. But if you've got dementia, for some reason you do not have the right to a diagnosis. Forty per cent of people never get a diagnosis.

CHAIR - Is that because they are not asking for it or they are not - or it is just creeping up on people?

Dr TOLMAN - Well, it is complicated - invite me back another time - but the reason is, that if I've heart disease, you can tell me and I understand; but if I've dementia, I don't know what's going on, that's why you need my family to help to make to the diagnosis. So, talking with me is not going to do anything. You need to talk with my husband, or father, or mother, or son.

Dr WALKER - And then just going back to your comment about the statewide provision of service, again, it's worth remembering that in the north of the state I think they have one geriatrician who doesn't work full-time at the Launceston General. In the north-west, I think they may have one-and-a-half geriatricians. Down here, we've got 12-ish geriatricians. So, clearly, statewide there is an inequity in the provision of that service. So, there is more that could be done to equalise that across the state and to be providing some statewide services.

CHAIR - That is really terrible, Stuart. Anita, you've got a question?

Ms DOW - I wanted to go back to the ComRRS program. When it's out of hours, can you apply to GP Assist for your patient or your resident for them be referred to that program? You can? So, there is that opportunity if the GP -

Ms PALMER - There is that opportunity; but then it depends on their workload, whether they can support.

Ms DOW - Okay, thank you. I just wanted to clarify that.

Dr TOLMAN - GP Assist are very likely to say, 'send to hospital', in my experience.

Ms PALMER - That's true.

CHAIR - Jane, what's the training pathway to become a geriatrician?

Dr TOLMAN - Intern; resident; registrar, then decide what you want to do within medicine; so, after that there's a three- or four-year training program for geriatrician.

CHAIR - So, we're training people to be geriatricians in Tasmania, should they want to take up that speciality. Is one of the issues that people aren't taking up that speciality?

Dr TOLMAN -There are 12 here, I'm told?

CHAIR - Yes.

Dr TOLMAN - I do not know who they all are. It is not numbers that is the problem. I am a community geriatrician. I do not see other geriatricians in the community too much.

CHAIR - I suppose from what Stuart is saying, if there's one in the north and one in the north-west, that's a problem, obviously that's a problem for people who live there. Do you have any view about what should be being done in that space?

Dr WALKER - That speaks across the health service with regard to recruitment and retention, particularly in the north and the north-west. Somehow, the Tasmanian Health Service needs to make it attractive to get these kinds of specialists to go there. You know, it's across all the specialities; surgical specialities, particularly in the north-west, and other medical specialities at the Launceston General. It is a recruitment and retention issue across all of health.

Ms DOW - To go to that, what would make it attractive? You're obviously a surgeon who has been working in Tasmania for a significant period of time. To your mind - obviously, there's a new pay deal done with hospital doctors more recently by the state Government - but that's something I have turned my mind to a lot, having been involved in local government and living in regional Tasmania for a very long time before being in this role. People give me different answers, and I am interested to understand what you think some of those barriers are.

Dr WALKER - I'm afraid I have not got an answer, because I think it is very difficult. If you think of a young doctor who has just finished their training, they have maybe lived and worked in a major metropolitan city where there's lots of action, lots of things happening, access to good quality schooling, access to good health, maybe a job for their partner, going to work in a rural centre does not seem attractive, because they might not be able to fulfil all of their goals and aspirations. If you go to a bigger metropolitan centre, it's much easier to do that. It's not just a question of money, although money is a factor.

If you were to ask a doctor to go and work in the North West Regional Hospital for $2 million a year, I think there'd be lots of people knocking on the door. They'll be there. But on the other hand, if you ask them to stay for five or 10 years with their young family, or with poorer access to the things I have been alluding to, they may start to think twice about it and say, 'Well, yes, I can probably tolerate it for a year or so, but beyond that maybe not" So, I'm sorry I haven't got a one sentence answer for you, because it is very complicated.

That's why I think, particularly in my speciality, we have provided a statewide service for nearly two decades now. So, there's a vascular surgeon in the north of the state every week of the year. We go up there and we try to do our best to provide that service. It surprises me how other medical specialities have not taken that on. In the surgical field, I can tell you that a statewide service is provided by neurosurgery and cardiothoracic surgery and that's it. In the medical field, I'm not sure there are any physicians who go to the north or the north-west of the state. Again, that alludes to what we've been talking about, maybe a bit of a cultural issue, so that we can expand our wings a bit more.

CHAIR - Any of the three of you, under the adequacy of the state Government's data collection reporting for transfer of care delays, you said in your submission that if data

collection reporting is taking place then the systems and processes that are being used are entirely opaque, and that the information from BESTMED and EMR is currently not coordinated and not accessible by staff outside the hospital system in the community sector. We obviously need to have that to be coordinated. This comment has been made by some other people talking about the fact it's crazy we do not have this information outside in a real-time display.

Ms PALMER - We use BESTMED. We have one GP that has the majority of our residents; he'd have about 98 per cent. We can email him and give an outline of a resident's condition, and he can go straight into the system from his home and update the medication chart as to whatever the needs are.

CHAIR - Great, that sounds fantastic.

Ms PALMER - GPs that come in, I can give them access to this system and allocate their patients so that they can do that.

CHAIR - Is your submission saying this currently isn't being used outside of the aged care sector or your aged care facilities?

Ms PALMER - My understanding is there's a lot of aged care facilities that use it.

CHAIR - Okay, and is this about sharing data or is this about using that same sort of system like in Ambulance Tasmania and in the hospital?

Ms PALMER - It would be great if everybody had access to that because that in itself if we couldn't access a GP coming in to the facility or calling a doctor or what have you then we could give a handover of a resident's condition and they could then go in - I mean, if they're filling up the fluid they can give them a diuretic into the system.

CHAIR - Without going into the minutiae of it, are you saying it's not about making one system that everybody has access to all the time but using the same systems you'd be able to transfer information from an appropriate medical professional or a professional to another appropriate professional?

Ms PALMER - We have electronic progress notes. All our assessments are all electronic, so we share data across the organisation.

CHAIR - How is it a problem this isn't happening at the moment? What sort of problems arise from the fact there isn't this data collection and reporting that's clear to people?

Ms PALMER - I can't answer that, but if they did -

CHAIR - You don't see that in patient outcomes or resident outcomes?

Ms PALMER - If everybody had access to these systems - these electronic systems - then the outcomes for the residents or patients would be significantly improved, but I'm not sure what -

CHAIR - Is that because their interventions would be more timely?

Ms PALMER - Yes, these interventions would be more timely, well and truly.

Dr WALKER - I'd interpreted your question a little bit differently, actually, because it's one thing which, again, has been raised by others at this committee. That is, the information that we have in the acute sector with regard to the availability of aged care and residential beds. We hear a lot in the press about the lack of these kinds of beds in the community and I hear from my colleagues that actually, it is bad, but it's not terrible.

CHAIR - That's what we've heard too.

Dr WALKER - There are times when the hospital is in lockdown; we just can't get patients moving at all. One of the impediments is that we can't get them out to the nursing homes or aged care facilities. That's because of processes both within the hospital but, also, we just don't know where the beds are.

CHAIR - You mean, the hospital doesn't know where they could discharge patients to?

Dr WALKER - Correct. Yet there doesn't seem to be a system within the hospital - a dashboard - to say, 'These are where the beds are and these are where we should be focusing our attention to try to get patients out to those available beds'. One of the problems with that, of course, is that there are some patients who don't want to go to that particular aged care facility. Therefore, we have to start having a bit of a discussion about is that right, is it right that we have patients waiting on a ramp while a patient is in the hospital, there are beds out there to which they could go to but they don't particularly want to go to that particular facility. I'm not sure that's right because their lack of transfer out is impeding other patients getting in.

Mr BEHRAKIS - You're not the first one to say that on the last two matters.

CHAIR - The mechanism would be anyway, leaving that aside about information sharing and data sharing, that there is software and systems, I don't know whether it would be BESTMED or EMR that would have the information about bed availability within a particular facility, and you're saying there could be a mechanism for sharing that in a hospital?

Dr WALKER - Correct, that would be helpful.

CHAIR - Are you aware if that's a model being that's employed elsewhere?

Dr WALKER - No.

CHAIR - Okay. Jane, do you have a view about that?

Dr TOLMAN - All I can say is that in 2011, when I was last in the hospital, the secretary in the Social Work department rang each nursing home every morning and there was a list generated of where the beds were available. I don't know if they still do that, but that isn't the issue really. The issue is that nursing homes get patients sent from the hospital in a completely different state from what they'd heard, families are ill-prepared for what's coming up, without a discharge summary detailing what's been happening, without medications. The nursing home may well be disinclined to take the next one that they want, whereas if you do my model with the family conference on day one, establish the goal of care, the family says, 'Yes, look, they

really need a nursing home', we talk about, 'Which nursing home are you thinking of? These are the ones that we know have beds, people can transfer, that's not an unsolvable problem'.

The availability of nursing homes is there, but we need people within the hospital to establish good relationships - trusting relationships - with the nursing homes and snap all the beds when they come up. I could get five patients into a nursing home bed tomorrow. I know where they are.

CHAIR - Simon, you've got your hand up, been waiting patiently.

Mr WOOD - Thank you, Chair, and thank you all for your time this afternoon. It's been really good. I'm interested to hear a little bit further about the notion of consolidating the acute older persons unit and aged services. Just a little bit about how you see the advantages in doing that?

Dr TOLMAN - I'm the person who set it up initially. The advantage is that each family has an opportunity to have input into what's happening to their loved one. Each family has the right to find out from the hospital staff what's happening now, what's going to happen in the short-term, but most importantly of all, what's going to happen in the longer term. End-of-life plans is a term we use meaning if you've got pancreatic cancer or heart failure, people will talk with you about what's coming up. That might be when the time comes you'd like to go to Whittle Ward or you'd like to die at home. When it's dementia, you don't have that talk with the person herself, but an older person's unit should have that discussion with the family at the time of diagnosis. Your mother's got a relentlessly progressive terminal disease, that's what a good acute older person's ward will do, liaise with families, have continuity of care, set goals, carry them out, what else is there? Does that make sense, Simon?

Mr WOOD - Yes, thank you.

CHAIR - Do you mind just laying out why that model you developed lapsed? That very substantial model you developed lapsed? What happened in that process? Why was it let go?

Dr TOLMAN - You can ask him. I'm emotionally involved in it, Stuart's not.

Dr WALKER - I think the model was slightly new to some established clinicians in town. What Jane was trying to incorporate as being good practice, and for the benefit of not only individual patients but for the Health Service as a whole, was not widely accepted by some of our medical colleagues. That led to some conflict and a breakdown of the unit.

CHAIR - Do you think times have changed? Do you think there is a receptivity in the community for that conversation? The merits, the value of it stands on its own, but in terms of the politics or the dynamics of what unfortunately shut it down.

Dr WALKER - I'm not sure, I think there is some willingness, because people see this problem day in, day out. You see the ambulances parked at the front door of the hospital; you hear about it in the press. You go to the wards and you see that the patients have been there for weeks and months and really ought not to have been there for weeks and months, so we see it all the time.

There is a degree of acceptance, because that's the way it is and to some degree, people have just given up. They've tried hard for a long time, it's just not working and nothing seems to be happening. I think there is a willingness by some clinicians to try to improve things and to make things happen. it's not just doctors, it's across Allied Health and nurses. So yes, I think things could change.

CHAIR - This is about leadership, isn't it? That's what could drive the change is to have that leadership?

Dr WALKER - Correct.

Dr TOLMAN - It's absolutely what the community wants. There is no doubt about that whatsoever.

CHAIR - Yes, I'm sure about that. The discharge summaries: it's just a small thing but I was shocked to hear that the discharge planning, which is the sensible idea of having the planning starting right at the beginning rather than happening towards the end stage and having one person who follows it through from - I think you said being initiated in - the emergency department. Do you think that's really realistic, given the pressures in the emergency department? Who would be doing that, thinking ahead about the discharge planning? Aren't they up to their eyeballs in trying to make sure that people are being cared for and kept safe, or is that something that should happen as soon as they get into an admitted bed?

Dr WALKER - No, it should happen in the emergency department. There should be geriatricians in the emergency department getting stuck into these patients as soon as they arrive so that we can establish their goals of care. We could be establishing expectations of what the patient thinks is going to happen or what the family think is going to happen. That should be occurring as soon as the patient is admitted to the hospital. Then, just going back to your issue about the discharge summaries, as you have already heard -

CHAIR - You said how unreliable and misleading they can be.

Dr WALKER - Yes. They can be. You've heard already from an experienced nursing home manager that patients are coming out to their nursing home in a condition which they weren't expecting and very often the medical discharge summary can be days or even weeks later and it's after the fact.

CHAIR - It doesn't come with the patient.

Dr WALKER - Therefore, what we're proposing is that if the patient is going to come, it needs to be as a package, which includes their medical discharge summary, nursing and Allied Health discharge summary, medications to last them until they can be seen by whichever doctor is going to be looking after them in the nursing home. You've already heard that patients can come to the nursing home late on a Friday with inadequate analgesia to cover them for the weekend. That puts the nursing home in a very difficult position, because they can't get the patient dealt with and, not surprisingly, they send them back to the hospital. That's all they can do.

Ms PALMER - We won't leave anyone in distress.

CHAIR - No, you can't, that's unconscionable. What do you think, is that just very bad management on the hospital's part? Is there a problem with getting - does preparing the discharge summary take a long time and they're trying to get people out of a bed?

Dr TOLMAN - I can tell you what I think. If somebody comes in, instead of talking with the family and finding out what has been going on for the past six months and the family can't cope anymore, they do a whole lot of tests, and then they do a few more tests because it is not obvious what's going on, and then they do a few more tests. The person might be 90 and is demented as. Then, the person's all of a sudden been in hospital for four months. The family is ringing me up and saying, 'I don't know what to do, nobody will tell me, they're saying Mum can make decisions for herself and you know, because you diagnose dementia'. Then six months later, there's a crisis and they're popped off to the nursing home without the family being ready, the nursing home prepared, the medications - it's all crisis management.

CHAIR - How can you have given a patient a dementia diagnosis and then they have to go through a separate whole process in the hospital?

Dr TOLMAN - You're the patient's GP, you give me a referral. I say this is exactly a patient I saw recently. I see the person at home. I meet with the family. Three weeks later, the person has a fall, breaks a hip, ends up in hospital and they do the needful and the family are saying to me, 'But they are saying Mum doesn't have dementia, she can make decisions for herself.' I say, 'Well, look, tell them that my letter is in the digital medical record'. 'Oh, they know that, but they think she is okay'.

CHAIR - They're not respecting the professional assessment that you as a geriatrician has made?

Dr TOLMAN - Dr Tolman rings up to speak with somebody and they say, 'We can't talk with you because you don't work here,' or, 'There's nobody available to talk with you', or, 'We will get back to you'.

CHAIR - Absolutely maddening.

Dr TOLMAN - Or, 'It's my patient and they will not talk with me about my patient'.

Ms PALMER - They will not talk to nursing homes, either. If I ring up to find out how one of our residents is going, 'I'm sorry, we can't give you that information because you're not next-of-kin'. However, when they want to send them back, suddenly we can get information.

CHAIR - They not only give you information, they give you the whole patient all at once.

Ms PALMER - Yes.

Dr WALKER - They give you the patient, but not information about the patient.

Dr TOLMAN - Can I tell you a story? This is a little bit long, but we're nearly finished and it's a really instructive story. A GP referred a very old man who'd been at the hospital under vascular surgery - I think you might have known him - and was in a really bad way. He was in a delirium and guardianship and power of attorney were appointed. His son was

appointed his financial administrator and effectively stole his house. He ends up in a little flat in Glenorchy with no furniture.

The GP has referred him to me. I work with a social worker. We get him access to some money at the Commonwealth Bank. We get him some furniture in the house. He says he doesn't want to go back to hospital under any circumstances. We take him to the local nursing home, make sure he has an ACAT assessment. Now, I did that with the social worker. Everything is in place. I get a missed call from him. I ring him back. He doesn't answer. Next day, I try again. So, I knock on the door, he doesn't answer. I ring the police. The police go there, he's lying in a pool of blood. I say to the ambulance who gets called, 'He doesn't want to go to the hospital. There is a bed at the nursing home. He's got an ACAT assessment, his GP and I will see him there and keep him comfortable'. The ambulance said, 'We can't do that, he's to go to the hospital'. There's the first problem. In the hospital, he's there for weeks and weeks, I can't remember how long. I can tell you his name if you ever want to check this case.

He's in hospital for weeks. I ring up, day 1, and I talk with some team. Day 2, I talk with some other team, there's been no handover. Day 3, I talk with some other team. Day 4 - this is all true - I talk with the team who's now looking after him, and, 'Oh, we can't talk with you because you don't work in the hospital'. Nobody would talk to me. Finally, after about four or five or six weeks, I thought I'll speak with the social worker, because I knew what was going to be happening in the hospital. The social worker said, 'We're getting him up to rehab'.

There is no way that man would have worked in rehab. After that, the GP rings me and says, 'Did you hear that he died?' I said, 'No, I didn't hear that he died'. My phone rang and it was the Registrar saying, 'I'd like to talk to you about Mr so and so'. I said to him, 'You do know that I have been trying to speak with your people about this man for the past six weeks?' He said, 'I was told not to talk with you'. He named the person who told him not to talk with me.

CHAIR - You were being black listed? The story that you give of a person being passed around from one day to the next to completely different care teams - that's bad enough - but it doesn't sound like there was information transfer or proper - you're all nodding that there would be no -

Dr TOLMAN - It is beyond belief, Rosalie. I have friends or colleagues who come here and do locums and they say to me, 'What is with this place?' The reason I started off with talking about New South Wales, that was bad but this is beyond belief and it's your fault. Your fault, because you've got the Premier, you've got the Health minister, they're not doing anything about it. It's your fault because you're not working together. This cannot be a political football anymore. It's beyond that. We're a laughing stock. Talk about moral injury. What about the patients? What about the families? Simon, you're new in this. You've got the opportunity to do something.

CHAIR - Getting back to this inquiry which is about transfer of care delays and ambulance ramping. What we've got here is a situation with aged care is this whole complex range of failures you're pointing to of poor communication within the hospital, woeful management of the diagnosis of dementia, and the pathway through the hospital including no involvement, usually, of families in that process. Then the person, at the other end, needs to be discharged, but there's not the information going to the aged care home to safely look after

them there to prevent them from having to be readmitted back to the hospital, and a huge lack of geriatricians around Tasmania and involved in the care that you do not agree with, Jane.

Dr TOLMAN - Twelve in the Royal.

CHAIR - Twelve in the Royal?

Dr TOLMAN - Yes. It's not a matter of the number of staff, it's a matter of the culture. What are we trying to achieve here?

CHAIR - They're all working hard.

Dr TOLMAN - Are they?

CHAIR - Well, I don't know, they're all paid and employed there. Did you have any other comments or questions, Anita or Simon?

Ms DOW - No thanks, Rosalie, I am good thank you.

CHAIR - We have traversed a fair bit of ground and there is a lot more to say. Thank you very much for the Newnham and Hill Report. We will look at that closely and that model of care in there. It certainly sounds like there's nothing new to invent here. It's more about picking up good ideas that have been there for a long time that haven't been enacted. Do you want to make any other comments about the next steps or for the Government or things that you haven't said that you wanted to add and provide to the committee?

Ms PALMER - I want to say one thing. I get families coming to me, particularly when one of our residents goes to the hospital, and they're complaining about the lack of communication. They ring up as the next of kin, they get switched through to this phone, to that phone, to this phone, and then they don't get to talk to anyone. They then come and ask me if I can ring the hospital and find out what is happening. That's not a one-off thing.

CHAIR - To be clear, the problem with bad communication, not just for the outcome for the patient and not just for the impact on the family about not being informed and the emotional burden about that, but it does have a relationship to patients not being discharged in a timely fashion, because -

Ms PALMER - Because there's no communication with the families. There doesn't appear to be.

CHAIR - Solutions aren't being found or problems aren't being worked through as early as possible. If that's not happening, then there are so many more reasons why a person can be bounced back into hospital or stay in hospital for a long time because they can't be discharged for months.

Ms DOW - That just prompted a question for me with Jeanette. I ask you as to whether you think that that breakdown in communication has got worse over time. I think you said you'd practiced for about 35 years. Is that something that's changed over time? Were those communication channels much better in the past? What time frame would you give to how that has deteriorated over time?

Ms PALMER - I've been in Tasmania 15 years now. Prior to that I was in Queensland. Fifteen years ago it was very different, but we had a really good relationship with the hospital, that was in Townsville, Charters Towers and Mount Isa. Since I've been down here, I started in the north and there was communication. We used to have meetings and things like that to discuss any prospective possible transfers and what have you. I've been down here for six years and I believe the communication has gotten worse. This, 'Look, you're not the next of kin', is a relatively new thing that has happened in the last six to 10 months I would think.

CHAIR - Wow, that's very recent. That's a huge problem when you're trying to have communication. Surely, there could be, 'I am from this residential aged care facility,' and surely, the staff, there's only be a few wards you would be ringing, surely, they'd know who you were and that can all be written down.

Ms PALMER - It's really disgusting when the families come in to clean out their room because a resident has passed away and we have not been notified. That's a fact.

CHAIR - That is awful. There's really no communication from the hospital and they are resistant to giving information out.

Ms PALMER - If they were coming back they would ring, sometimes.

CHAIR - Stuart, did you have anything else you wanted to say.

Dr WALKER - No.

CHAIR - Thank you. Jane?

Dr TOLMAN - Obviously, I've a lot of emotions and I want to thank you so much for inviting us to talk. Doing the submission was a bit of hard work but we are delighted to be able to have our say. I have been trying to meet with the Premier and the Health minister for a long time. I did meet with the secretary of the Department of Health some years ago. She brought in the minister who listened to me for 10 minutes and said, 'We are putting a lot of money into health', which is totally not the point. This is before the current era. You have the opportunity to do something about it and I do really wish you well. We're not only frustrated health professionals, this is our community. We want to see things better. We would do anything to see things better and we cover the gamut of the health system in Tasmania. Thank you very much Anita, Simon and Rosalie.

CHAIR - I want to assure you we're working really collaboratively on this committee and we are all very committed to finding outcomes. We know it is a big picture problem. We know it is not going to be solved overnight. We also know there are also really short-term things that can make a difference as well as putting things in place for the longer term. Thank you very much again for your contributions, it's been very helpful.

Before we leave, I want to remind you again, the information you have given us today has been protected by parliamentary privilege. When you leave the room, you need to remember the privilege does not follow you outside when you make comments, including in the media, even if you are just repeating what you have told us here today. Is that clear? Great.

THE WITNESSES WITHDREW

The Committee suspended at 5.15 p.m.