PUBLIC

THE PARLIAMENTARY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON WEDNESDAY 24 JANUARY 2024

The committee met at 9.02 a.m.

CHAIR (Dr Woodruff) - Good morning, Bruce Levett. Before we begin, did you receive the guide from the committee secretary which gives information about this committee?

Mr LEVETT - I did.

CHAIR - It is a committee of parliament, and for us to be able to do our work you are provided with parliamentary privilege, which means that you have the freedom to speak without any fear of being sued or any other court action. It gives us the opportunity to have frank conversations. That parliamentary privilege doesn't follow you outside, so you need to be aware that you are covered while you are sitting here and talking to us, even if you say similar things when you are outside. You understand?

Mr LEVETT - Absolutely.

Mr BRUCE LEVETT, CEO, HEALTH CONSUMERS TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - The committee has your submission. This is Simon Behrakis, another member of the committee and we have read your submission. Would you like to start with an opening statement or comments?

Mr LEVETT - It is important to understand the context of our submission and it underpins our work and the feedback that we get across Tasmania from within the system and from the community. There are six high level overarching issues. One is access. Access is getting more difficult. For many people in regional areas, it is now impossible, and that has a big impact on ramping and ambulance and getting into ED.

There is an issue of continuity of care and increased use of locums, so that corporatisation of healthcare is having a detrimental effect - we believe - on what healthcare is there to do. It may not be quite so central to today's conversation. People want to be treated and supported in their communities when it is safe to do so. Again, that has a big impact with ED and what services and how ED reaches into the local community. Prevention is a big issue for the community and that's an unspoken issue that this committee needs to look at in terms of ramping and getting into the hospital, because if we don't play in the prevention space, we will never fix the hospital space.

Navigating the health system is difficult and for many people it is becoming more difficult. For people understanding how to call an ambulance, as simple as that may seem, is hard and complex, and there's a whole lot of complex issues around why people will not call an ambulance that we can talk about today as well.

Health is more than just hospitals and GPs. We do focus on the hospital and the GP issue, but when you talk to the community, health is much broader than that. For example, we did a survey late last year of our community of interest, which is about 900 people, in terms of what

their priorities were for health and if there was an upcoming election. Housing was the number one issue that they put on, from a health context. Health is much broader than hospitals and GPs. I believe the challenge for this committee is how do you focus on a particular issue. If you ignore all the other important issues around it, you will not fix the issue that you are looking at. That's our view, and the view of the community.

The last thing that I will say as an open statement is that the ramping is visual. It is something that the media see, it is there every day or most days. Our focus in today's conversation is that the ramping extends into the community and it extends into the regional or remote areas. We see ramping as not just the ramping the hospital but it goes right into and deep into global communities.

When somebody is in a local area, a regional area, and they are faced with the decision of, 'Do I call an ambulance?' the issue of ramping is present. Some people won't call an ambulance because they do not trust that the ambulance will turn up in time. Some people won't call an ambulance because they know that in their location there is only one ambulance, and if they take that one ambulance it is offline for at least two or three hours. It may only have one or two trips that evening, and therefore if they get caught at the hospital and there is ramping, they may be the only person who has access to that ambulance for that evening.

You might have someone who is quite unwell and deservedly needs emergency treatment, but they will sit back and go, 'Maybe someone in my location could have a heart attack - if I have the ambulance what happens to them?'

For us, the ramping issue is alive and well. It is an issue in regional and remote areas more so than in urban areas. It is more of an issue for those in low socio-economic areas as well because they rely on an ambulance to get to the hospital. If they are sick, if they need to get to the hospital quickly, they may not have a support network around them. They may not have a family who can drive them, they may not have access to a car that can get them into the ED. They have to wait for an ambulance; they have no alternative. Again, we believe ramping has a greater impact on those in low socio-economic areas.

CHAIR - Thank you for those comments. It was very clear from the individual comments from people that you have embedded in your submission that there are different ways that ambulance ramping affects people in rural areas. I would like you to tease that out a little bit more. On the issue that people do not have any other choices - we have heard from other people who have presented to the inquiry that there are no other health options after hours in rural areas. There are two parts to that. Can you talk about the availability of health options in rural areas and what you are hearing from people, and also about people who will have to call an ambulance because there is no transport, they have no other option?

Mr LEVETT - If we flip it around, there is a conversation in government and in the community that people who live in rural or remote areas do so by choice. They make a decision that they are there and there is no healthcare, and they do that in an informed sense. What people do not understand is that in places like Ouse, people have lived there their whole life. They grew up with a local hospital, they grew up with the local services in that community, and the health industry has moved away from that and then turned around and said, 'You are out there, you live there by choice.' The industry does not realise that it has moved away. It is concentrated.

We see that with GP access. With Greenpoint, owned by a corporate, they had a centre in Sandy Bay, they had 17 GPs. As a corporate organisation, they couldn't get two or three GPs to drive up the river to a poorer area to keep Greenpoint open, and needed another service provider to come in. The GPs are there, but for whatever reason they don't want to work in poor areas, let alone remote rural areas.

We're seeing that with the conversations in East Devonport at the moment. We can't get - it may change - but at the moment we can't get GPs from the Devonport city to cross the river and service people in East Devonport, not realising that people in East Devonport don't have transport, don't have mobility. For them to get across the river, there is no ferry. They just can't do it.

So, it is that the health system is moving away from poor areas. If you live in Sandy Bay, you'll get a doctor. If you live in the Midlands or on the east coast or the west coast, it becomes very problematic. Health care shouldn't be driven by postcode and where you live.

For us, the whole commercialisation of health care has taken it away from a community service perspective. Then, you take that to your question about someone in a remote area. They just don't have access to after-hours. They just don't. So, the system's response is call Healthdirect, they will help you, and often their advice is, 'Well, go and see your GP'. That doesn't help if you don't have a GP. Or actually, 'We can give you a script to get some medication that you need urgently'. The pharmacy doesn't exist or is not open.

So, part of the system thinks it's got a solution, but for those on the ground it does not work. Again, if we look at the Tasman as an example, and you look at the volunteer first response, I think at the moment they only have one volunteer who's doing that role. You can't do that role every night all the time. What happens there when someone is sick? What do they do? There's one ambulance, I understand, down there. If they can't staff that ambulance, then there is literally no access. So, if you need urgent care, you won't get it. You will have to wait. And then what happens during the day? Yes. That's still problematic.

CHAIR - That's a substantial-sized community - a whole council area - where people have lived for their whole lives, as well as tourists who come in who arguably might have transport options, but there are many people who have no transport options.

Mr LEVETT - Yes, and the work that we're doing in Scottsdale, for example, transport is a big issue there as well. Even in that location, there's no taxi. There's one or two buses a day into Launceston. What do you do if you don't have transport? If you're so sick you can't drive, you cannot get health care. That is all part of - I hate the word 'downstream', but that is the local problem that then manifests itself with ramping and in the hospital. For us, if we don't fix after-hours care and health care in the regions, we will not fix ramping. I don't care how much money they spend. I don't care what they do in the hospitals. It will not completely fix ramping, because it's all related. It's not working.

CHAIR - What do you think - are there any regions in Tasmania that are attempting to turn around this model? I'm thinking here of Cygnet Family Practice that has started down the path of addressing some of those issues.

Mr LEVETT - Yes. So, if I talk about Ouse as an example - I think the year before last the GP practice left. I think it was the year before last -

CHAIR - I think so.

Mr LEVETT - It was about - yes, so they had no GP. There was a promise that they would try to get a GP to service that locality for a period of time. They could not get a GP to do that even a day a week. They couldn't get a GP for whatever reason to go from Bothwell or New Norfolk or wherever. It just did not happen. So, that community was stressed. It was upset, angry because it had no health care. The work that we've done with that community - they realise that just advocating for a doctor is not the solution for them.

They met the Health minister late last year and they were really clear on what they wanted. They told the minister in blunt terms - and it's really interesting, the minister met the service providers just before he met the community. The service providers, you know, they're doing a really good job. They're working hard, but they still didn't understand what the community wanted. They were going, we're doing - you know, the community nurses, they're great people. They work - and this is not a criticism of them, but they were doing a lot of house calls because that's what they thought the community wanted, so they were always out and about. The community health centre there was mostly closed. The community would not go there because it is always closed. Why take the trouble - and it is big trouble to get to that centre for those that live in that area - why do that when it is closed? Yet, the services thought they were doing the right thing by going out to the community.

The feedback from that community was, 'We want transport so we can get into the centre and allows the community nurses there to stay in the centre so we know it's open'.

CHAIR - Transport being a community transport option?

Mr LEVETT - It could be community transport; it could be taxi; it could be whatever. They needed transport, so they started to advocate for that. They wanted the centre to be open longer hours. They have asked for a nurse-practitioner-led model, because they can't get a GP. They are really keen on a nurse practitioner model that has a paramedic - what's the term for those extended-hour -

CHAIR - Extended-care paramedic?

Mr LEVETT - Extended-care paramedic. We believe that there are some paramedics who have retired up there who may do that role. They wanted that as a package that is supported by a really strong telehealth service into a GP somewhere. They felt that model of care would work really strongly for them.

CHAIR - But your point is that is specific to that community, it is not a press repeat. It's community-specific and demographic-specific. Different regional and remote communities have different demographics with different needs, and that thing would need to adjust over time. Who was taking carriage of that work?

Mr LEVETT - The department. We've met the deputy secretary in the department and we understand they are looking and trying to make all those actions happen. We met them in November last year, so it will take them three or four months to make that materialise. If they can, we think that's a good thing.

CHAIR - Would you then think that it would be the role of the department to have a look proactively at all of the regional communities around Tasmania to come up with regional solutions?

Mr LEVETT - Absolutely. You've nailed our position.

CHAIR - Because otherwise, GPs are going to leave and things are going to get worse, and services are going to contract.

Mr LEVETT - Yes. We argue strongly that the community has the answers to what services they want. They'll actually make it easier for the bureaucrats and for the politicians, because it is very easy for the bureaucrats and the politicians to believe, and the health system is going, 'Hey, let's build a model here. It works, if we refine it and it works in this location, let's just roll it out across all -', and it never works, and they don't understand why.

Our learning from our health and wellbeing networks is that we believe that the funding is needed to mobilise a community to have conversations about what services they need, how those services can be targeted in their location. Then the department can come in and work with each community separately to customise whatever services they need. You're right: every location is different, and the package of services will vary, and the community will also know when there is duplication of services.

For example, in Scottsdale, the community group that we had up there, the feedback was that there were three driving-out mental health service providers all funded by different bodies, different levels of government, who didn't talk to each other, who didn't explain or share their referral pathways. The community didn't know which one to go to. So the community said, 'Well, we don't want to lose the funding that's coming into our community, but we actually don't need three of you. We actually might need one-and-a-half of you'.

They are the conversations that the community will have to reform health care, and then that takes the pressure off hospitals, because those people who need the mental health support will get it. It is a preventative support; they are looked after in their community and they don't spiral into a position where, bang! - they need ED for whatever reason.

The communities understand the preventative health approach. They won't use that word, but they use the word 'we don't want to get sick; we don't want an ambulance; we don't want to end up in ED'. But we need help to understand what that means for their life.

CHAIR - Who should lead the community conversations? There is a lot of skill in doing that work.

Mr LEVETT - I believe we are successful in doing that, but this is not about us; this is about the community. Each community is different. We would argue that the community is mobilised and we believe a non-bureaucratic organisation needs to be a backbone organisation to help the community have conversations that empowers a community to come together and work in a way that works for them. We would advocate a process that engages a community and then lets them go, rather than a process that would go across all communities. We've demonstrated in Huon, Tasman, Scottsdale, Ulverstone, and Ouse, that if you do empower the communities they will be solutions- focused, and that's really important.

CHAIR - Yes, thanks.

Mr LEVETT - For us it's really important, because if we don't fix that, you'll never fix the ED.

CHAIR - It's interesting. healthdirect has come up as an example of something that could be used more. One of the quotes that you've said is healthdirect was described as a 'useful service for after-hours or for people who cannot access a GP, but many people don't know about the service'. You've made it clear that healthdirect can't be useful in many situations but it obviously is useful in others. What's the problem with information getting out to people in the community?

Mr LEVETT - There is too much information; there's an overload of information. I also believe, and the Government and the department have told us, that they're not good at communicating with communities. The previous secretary of the department said that, from his perspective, bureaucracies have lost the art of communicating with the community. They don't know when, they don't know how to talk to them, and they don't know what questions. There's a whole lot of issues around that communication that just don't work.

The other side of it is the trust issue. What we are seeing is that, in the community, there is a declining level of trust in just about every institution. With respect, I think there's a lack of trust now in a lot of politics. There's a lack of trust in the finance industry, the aged care industry, the religious industry, and, unfortunately, the health industry. People, now, don't trust a lot of the advice that comes out of the health industry. COVID-19 and the issue around vaccinations brought that to the fore. So, it's on both sides of the fence.

As a system, we've got to look at different ways of communicating with different pockets of the community, otherwise there will be some good services - and healthdirect does work for some people, but if they don't know about it. The number of 'kitchen tables' that we've hosted where the feedback that comes back is, 'This is great.' We've learnt what's in our community by talking to people in the community, because they know.

An example where communication doesn't work - we get a lot of negative feedback when the department puts out notices saying, 'The hospital is full, please don't turn up to ED'. There is often a notice that comes out from the department that says, 'If you don't really need to come to hospital, don't come today. They're ramping'. That impacts on the community's trust in the system. It transfers the problem or responsibility to the person, rather than the system taking that responsibility. Because people say, 'Maybe I shouldn't, should I?', whereas when they need help, they need help. It makes people second-guess. That's an example where official departmental communication, we think, is detrimental to a bigger picture as well as what they're trying to fix at the moment.

CHAIR - Do you think there's a risk that people are suffering adverse health events alone in their homes because they're worried about calling an ambulance?

Mr LEVETT - Absolutely, and we've got evidence. I think some of our quotes highlight that people do suffer unnecessarily because they won't call an ambulance because of the trust issues, the timing issues. There's some quotes in there of people who rang an ambulance and waited hours and hours.

CHAIR - Person from Huonville:

> I was in excruciating pain in my stomach, I thought I was dying. I was vomiting hard and crying my eyes out. It took six hours for an ambulance to arrive after we called. I was terrified and in excruciating pain all the time.

Mr LEVETT - Yes; and we've had other examples where people have waited and they've realised well if we knew in advance the wait was going to be this long, then we would have made other arrangements.

What we find frustrating is, you can call a pizza or a taxi and you know exactly where that pizza or taxi is on the road and you know exactly how far away it is. If you call an ambulance, you haven't got a clue. No idea. You're looking at other sectors that are using technology really well, but for whatever reason the health system refuses to pick up what we call basic information that informs the consumer about where their care is as. If you're sitting in Huonville and you realise that your ambulance is not there and is not coming, it is still in Hobart -

CHAIR - You know that they have to come from Hobart and you're in Dover.

Mr LEVETT - You're in Dover - you may, if you can, try other sources of care.

CHAIR - You would advocate for information coming from Ambulance Tasmania to people, especially in regional areas, about how long it's going to be?

Mr LEVETT - Absolutely. To us that is basic information and informs a person if they are in a position to make other arrangements; and it might be just pain care.

Mr BEHRAKIS - It might be for someone to organise for mum to come and get me and take me somewhere where I can get looked after rather than sit there for two hours waiting.

Mr LEVETT - Yes; or mum comes and just holds my hand. Even that care support is important, sometimes.

CHAIR - A question about the comments you made about the 2019 report from the Auditor-General on the performance of Tasmania's four major hospitals in delivering emergency department services. I well remember that report and some of the health consumers views at the time. There was a workshop that some of us here attended, and promises were made at the workshop.

You were talking about culture change. The Auditor-General highlighted the poor and dysfunctional culture across and within hospitals as a major issue. There was a commitment to fix the culture, but there was no discussion to fully understand or own what the culture problem is. Without the commitment to resource and fund change, you were definitely not certain and only hopeful that the culture problems will improve. Is your view now from reading elsewhere, that the culture problem hasn't improved since that 2019 report?

Mr LEVETT - No, I don't believe things have improved at all, unfortunately. I sat in that room all day and listened to senior executives of the hospital almost dismiss the issue as if it is not a problem. I sat there during the day going, 'If they don't own the problem, they are

not going to fix it'. I then watched the department put out about three or four pages of enormous amounts of recommendations and if you looked at them, they were all underway or completed. Clearly, there was no focus out of that meeting. With these issues, if you've got five pages or three pages of recommendations, you clearly haven't got a focus of what needs fixing.

Our ask was that the Auditor-General come back in 12 months and do an independent assessment of whether things have changed or not. That was ignored by everybody. We believe that a recommendation here could be that there is an independent oversight of any reform program so people are held accountable. Just to make some recommendations - and I think your challenge as a committee will be, is this report number 12 or 13?

CHAIR - Thirteen, I think.

Mr LEVETT - Thirteen in the last 20 years? One every two years. You don't want this to be the report from this current two-year period that just goes on the pile. Somehow, we've got to cut through the reporting and recommendations. There needs to be accountability, and it has to be public accountability. We would argue, an Auditor-General or a commissioner - someone outside the health system - who has the authority to say, 'Here is a whole lot of recommendations'. The Auditor-General's recommendation are still valid, I believe. We need a process that does change that system - because if we leave it to the system to change, they don't have the capacity.

The internal politics will stop any meaningful change, unfortunately. There are the different players and you will probably get it here with all the different groups that are trying to push their own perspective. It is not a consumer-driven change. You have a whole lot of self-interests, people trying to change, and then you have a self-interest of status quo or defensiveness. We need a way to break through that. I don't know the answer to that. It is beyond me. All I would argue the suggestion there of an independent arbitrator who can say, 'What have you done? Prove it'.

CHAIR - The Auditor-General could be such an external body, or there could be another specific body that is established with independent oversight of actions. Are you aware of any other jurisdictions where they are doing this well?

Mr LEVETT - No. Unfortunately, what we are seeing in Tassie is happening everywhere. The quote we have used is that Adelaide built a new hospital of 500 or 700 beds. Don't quote me on the number. It was going to fix their hospital ramping issue; and within three months that hospital was ramping. Tasmania has the opportunity to lead that reform and the nature of us, with the one Primary Health Tasmania, the Department of Health. We can if we are brave enough, if we get the federal government on side as well. As we have been talking about, it is not just a 'your problem, not our problem' issue. It is everybody's problem, so all levels of government, all stakeholders, have to own the problem or we won't fix it. I don't know how you break the self-interest.

CHAIR - One of the things that Tasmania has that many people would agree on, is we do have connected communities and strong community culture, so there is a great will overall to work together and to hold people who make these decisions to account. That is something that I hold hope in.

Mr LEVETT - We can work with a community to help with accountability at a regional level. How we will do that I don't know; but the community ultimately is the arbiters because they can see what is happening on the ground. The stats will tell us one thing but they will amplify that. How we get that connect I don't know. We are happy to have ongoing conversations about that.

CHAIR - I see Anita has her hand up. I have one more question, Anita, and then I will go to you.

It is what you said about putting the patient, the consumer, at the centre of all decisions that are made. Can you talk about why this is being resisted? I am quite shocked, and many people would have heard the rhetoric for years and years now - 'We have patient-centred healthcare'. It is the sort of thing you see on posters around the place. Why isn't this happening? Why is that being resisted? The evidence shows that you get better health outcomes when you put the patient at the centre. Is that the cultural change you are talking about, or the culture which is holding it back?

Mr LEVETT - That is part of the culture change we are talking about. The other part of the culture change that is happening - but happening too slowly - is getting consumers in decision making processes so they can influence the change in a way that works for them, not in a way that works for a particular industry body. It is having consumers who drive that reform process.

CHAIR - Which requires some relinquishing of power from the bureaucratic agency.

Mr LEVETT - For example, I think it is the Alfred Hospital in Melbourne. They use consumers slightly differently. When they recruit a new CO for the Alfred Hospital, there will be a panel and there will be a consumer on that panel. I was told that that consumer had right of veto. You could have four people going, 'Hey, this would be a great CO, we like the culture,' and if the consumer goes, 'No, that person is not appropriate,' they start again. That is the sort of power that we are talking about, not having a token person who is one consumer amongst four or five professionals. They have no power. It is actually making that power balance even, and we would argue could even swing more to our community perspective. It is an issue of power because consumers will not play the politics of -

CHAIR - Self-interest.

Mr LEVETT - Self-interest.

CHAIR - The community to represent them, to hold them to account.

Mr LEVETT - They will look at things as they are and they will make comments, and they are educated comments too. You are not asking a consumer to design a new heart surgery process. You are talking about a consumer making sure the process works. If there are blockages and they can see those blockages, being able to call them out, because there is no self-interest.

We think the department is making - I have been reading this for over six years - I have seen the beginnings of cultural change in the department, but it has a long way to go. We still need the department, we still need the hospitals to move away from, 'We have a consumer

group, we will use them when we think we need to use them,' or, 'We think this is important for them to comment on but maybe these others are not.' We need consumers at the table to say, 'Hey, these are issues that have to be discussed.'

We need greater community input on all these other issues. It is changing that balance. It is having consumers on the decision-making bodies, whether that is the executive within the department, in the executives of hospitals, they do not exist. We think that would be a cultural change, and someone we could lead on.

CHAIR - Thank you. Anita?

Ms DOW - Thanks, Rosalie, and thanks, Bruce, for presenting to our committee this morning. I wanted to draw your attention to point 4 that you make around your recommendations. You mentioned health literacy and the importance of improving health literacy across Tasmania. I wondered if you had any suggestions or advice to this committee about how we go about that? One of the barriers to consumer participation is obviously health literacy. Do you have any further remarks or thoughts about that?

Mr LEVETT - Each community would do that differently. Health literacy is about understanding your body, it is about being able to understand medication, it is about understanding what services are available, it is about how the system works. That is all part of health literacy. An example in Scottsdale: they, for the first time we believe, got about 38 service providers in a room. They had about 400 locals go through that hall and talk to people about what services were available. For them, that is how they started to address health literacy. They had about 400 people go through a health and wellbeing expo in Scottsdale. They had a school bus turn up with about 80 kids who spent half a day there.

If you want ways of changing health literacy, it is about how you connect the community to the services, and to be able to have open conversations about health and wellbeing. For a young kid in Scottsdale, 'You provide mental health support, what does that mean?' That beats a brochure, that beats advertising, that is how we think the community wants to be informed. Particularly in Scottsdale, that worked really well. That is the first time they have done that. They want to do that every year. If they can be resourced, that is what they will do.

That is part of the solution, getting the community to understand what is important to them in terms of health literacy. It could be, 'What food am I eating, how do I access proper food?' because that is all part of health literacy. In three of our regions that is a really important thing for people to understand, 'How do I cook healthy food, how do I access healthy food? I can't, well then how do we go about those sort of things?'

Again, it's that unspoken: health prevention. Health prevention is so important that if you get people understanding those sorts of things, they can actually make decisions that work for them. I probably haven't answered your question, Anita. Does that - it's, because it is a really deep issue -

Ms DOW - That's okay. I thought it might be useful to have some examples of some of the work that health consumers have done around that or that point to any other jurisdictions that you think have done that well or different models of how they've improved health literacy across their communities.

Mr LEVETT - For us, it's the community conversations that really, really work. In the Huon, there was a group of blokes who did a kitchen table.

CHAIR - That's right. That was about three years ago.

Mr LEVETT - Yes. I think it was in the pub. They started talking about health issues that they could raise in that environment with a beer. They had one beer, no more, but they couldn't talk about health issues at home. They couldn't talk to their partners or their family about what was happening to them but they could amongst themselves. For us, it's that enabling that allows people to have that permission to ask questions about health and therefore their health literacy rises.

It's the same - there was a group down there, I think it was in the Huon, there were women suffering domestic violence. They came together and they started talking about how they get support where they couldn't get support. So, for them, the health literacy was how do they get peer support to help them through those issues. They have continued to meet and they provide that wraparound support. I understand now they are opening their doors for other women to come in who may need some peer support. For us, that's all about health literacy and it's dealing about a particular significant health issue that's happened in their life. So, that's another example of the community providing that support around health literacy.

You know, brochures, you can spend years refining the words and pictures in brochures and they work for some people but for us it's that conversation that we find really, really important.

Another example about health literacy: we did a kitchen table on the Tasman. I might have mentioned it before somewhere. Women under 35 who would not go to the health system. They would not put their hand up. They did not trust the health system. They did not trust the local GP. So they had conversations and understanding why they wouldn't engage with the health system because my understanding was one, maybe two of them, did and the only reason they did is because their home birthing went wrong. They needed to be flown to the ED for emergency support. Otherwise, they did not want any proper, professional health care around them.

For us it's you get them talking, you get that trust building and that helps their health literacy in what we think is a really meaningful way; whereas most people talk about health literacy as about a piece of paper. If you can't read, it doesn't matter how well you write something, it has no impact.

CHAIR - We're talking about a long tale from what people who are listening might - you know, here we are talking about an ambulance ramping inquiry but really you're going into detail about many of the issues that other people have provided us with, which is that we can't just focus on the ambulance ramp. It's a whole system issue and if we don't also look at what is driving people to come into the hospital or, as you're saying, not go to the hospital so that their condition may well get worse, then we won't be able to have a real long-term impact on the ramping.

What you're talking about are your health consumers. You're talking about transport, housing, literacy, health literacy, trust. These are all part of what is called the social determinance of health, aren't they, which you have mentioned in your submission. I suppose

what you're presenting - what you're advocating for is for the health department to open up and recognise all these factors and rather than being so just stuck on health and that the consumer's voice, is this what you're saying, the consumer's voice is one very important, maybe not the only way, to get that part of the culture change that needs to happen.

Mr LEVITT - They need to be at the table. They can't do it on their own. They need to be part of the solution. I could cheekily put out the challenge for this committee as you develop recommendations. I am sure we could help test those for you, in confidence, in a way that makes them from a community perspective, say, 'Hey, they will work'. Or maybe there are some issues that you have to think about further.

Again, it is about how we culturally change how we do things. For us, the department, there have been a lot of jokes that it is the department of hospitals not the department of Health. We have heard that a bit. Again, to be fair to the department, they are trying to move away from that a little bit. If you look at the budget that this government spends on health preventions versus the rest, we spend nearly 30 per cent of our budget on health. I don't know the number. It is hard to find out, but the percentage of that that goes into health prevention, I think it would be less than 1 per cent. Maybe even less than half a per cent.

CHAIR - I'm sure it is.

Mr LEVITT - What we are doing - it is the old adage of you've got a dam that is overflowing. You've only got so many fingers. You are putting your fingers in the hole trying to fix the dam, but there is no effort going upstream to actually stop the dam. That is pretty simplistic. The prevention stuff for us is, if you don't fix that, we will be here in two years' time and two years' time and two years' time, still talking about the core issues.

CHAIR - On recommendation number 3, you talk about declining access of availability of services. You have already spoken about this. You recommend more varied and varied entry points to enter the system, not just through general practice, which is for many reasons declining in rural areas, and you advocate deep reform in the primary care sector.

You suggest establishing new roles or functions to provide continuity of care to help navigate people across visits and health services. What do you mean by new roles or functions?

You've talked about kitchen cabinets. That's a very downstream localised way of doing it. It will take a long time to have kitchen cabinets across the state. It is a great model, but what else do you mean?

Mr LEVITT - Health care is changing dramatically. I don't think it is just tweaking current roles. I think we need to really examine the roles and responsibilities of our health professionals.

If you look at nurse practitioners, it is about how can you change their scope, if need be? How can you expand their scope? Is there a new role? Is there a different way of doing that work?

Pharmacists: we have evidence that people now go to pharmacists regularly to get advice that they used to get from their GP because there is no GP, or they can't see their GP? How do we work with our pharmacists in a different way? It might be a different role.

Mental health is doing some good work in peer support work, so, why don't we have peer support work for communities in general care so they are not doing the role of doctors or pharmacists or nurses, but they might have a bit more knowledge on 'This is what you need to do' or 'Okay, I can call for you. I can support you'.

They need to be paid roles; they can't be volunteer roles. We have to think differently how people can access or get into the health system. We have to be innovative. It used to be GP-centred care; you'd go to a GP and then they'd float. That doesn't work anymore. The reach of GPs doesn't work in Tasmania anymore. We think that model is now broken.

What new roles can we work up and train people so that they can provide that initial entry point, that initial triage? I don't know exactly what they are, but there is now a big gap in the community.

It could be someone who was a first aid officer in a corporation who has some basic knowledge of first aid who can actually say, 'You need help and I know someone. Bang, this is a process for this community to get you into the system and then, 'off you go'.

Or they might have access to telehealth so they can say, 'Yes, come to the chemist. There is a telehealth system set up. Let's go and I will sit next to you and we dial you into a doctor in Sydney and we get help that way'. Again, telehealth is great, but we believe it is so narrow. You can't use telehealth unless you have already seen a GP once, face-to-face, so it doesn't work. For example, Smithton, the woman there had a female GP, that GP was on leave - correctly - needed leave. They only wanted to see a female GP. There were none in Smithton, so what do they do? There is one in Burnie, but they couldn't get to Burnie. They couldn't telehealth that person in Burnie. They had to go there in person. They couldn't get there in person. Telehealth is a great service but the system has locked it down. So it doesn't work for the community; it works for the system.

That's an example where you could have a non-medical person sit with someone while they telehealth into a GP who may not be in the state, who is set up for that one reason. If you are really sick you don't remember what's going on, you find it hard to articulate, you are stressed and you don't remember. If you have a peer worker next to you to take notes, ask questions, that could be a new role that could help a lot of people in regional areas. You may not need a GP in that region or even in the state, but that person is still accessing healthcare. That could be an example where we totally change how we do healthcare. That is not our idea. It has been put to us.

CHAIR - In Tasmania?

Mr LEVETT - Yes, that could work.

CHAIR - Unfortunately, we have to finish now, Bruce. Thank you so much, Bruce Levett from Health Consumers. We appreciate your detailed submission and all the work that Health Consumers do in providing the community perspective and advocating for community and better health outcomes.

Mr LEVETT - Thank you.

CHAIR - Before you leave, I remind you that everything you said here is covered under parliamentary privilege and when you leave, parliamentary privilege doesn't follow you out the door, even if you are repeating things you have said here today.

Mr LEVETT - I don't think I have said anything that will get me into trouble.

CHAIR - No.

Mr LEVETT - It has been a privilege to be able to share some more and we are happy to provide more feedback, if need be. Whatever support you need, we can help.

CHAIR - Thank you. We appreciate that.

THE WITNESS WITHDREW.

The committee suspended at 9.52 a.m.

The Committee resumed at 10.00 a.m.

CHAIR - Hello, Tom Millen, thank you very much for coming down to talk to us today. Just before you start, did you get the guide that the secretary of the committee gave you about the proceedings today?

Mr MILLEN - Yes, I did.

CHAIR - It is covered by parliamentary privilege, and that's so that we can do the work of parliament and get the best information possible, and so that you can speak with freedom knowing that you should have no fear of being sued or any other court action taken against you. It's important to understand that what you say here today is covered by parliamentary privilege, but if you go outside, even if you were to say the same words, you wouldn't be covered in that space. Do you understand?

Mr MILLEN - I do understand.

CHAIR - Today will be streamed publicly, and there will be members of the media and the wider community who might be watching. You've got a statement in front of you. Could you please read that?

Mr TOM MILLEN, REGISTERED NURSE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you. We've got your submission. Thank you very much for the detail. We've got lots of questions that we would like to ask you. Would you like to start off with a statement or any comments?

Mr MILLEN - Yes, I would. To the members of the committee, thank you for this opportunity to come before you today. Acknowledging we are on Aboriginal ground, and in this place, there's mixed emotions for many people, but I feel that being in the house of democracy is a wonderful place to be, so I feel a great opportunity to be here today.

CHAIR - You're a registered nurse?

Mr MILLEN - I'm a registered nurse. I've been a registered nurse for 20 years this year. A veteran, some would say.

CHAIR - At the Launceston General Hospital?

Mr MILLEN - Predominantly at the Launceston General Hospital. I've also worked on the mainland, in Victoria and in the Northern Territory, but the majority, over half of my career, has been at the LGH, where I've worked predominantly in the emergency department at the LGH, but also, I've worked on most of the wards.

Currently, I'm working in the School Health Nurse Program in the north of the state. I'm still casually employed by the Tasmanian Health Service and work very intermittently now at the LGH, but my primary employment is with the Department of Education, Children and Young People in the School Health Nurse Program.

Today I'm here to speak about my experiences mainly at the Launceston General Hospital, and I guess I have very mixed emotions about that experience that I've had. It's an amazing place to work and amazing people to work with, and I feel that my colleagues across all fields, whether that's nursing or the medical profession or allied health or the ancillary staff, I really believe that the people who work in those roles have a real calling to public good and to serve their community, it is a real honour to be able to serve the community that you live in.

I was fortunate enough to start my career at the LGH. In the very early years, I think it was around 2006, I worked in the emergency department. I am one of the few people who are continuing to work, unfortunately, from that era, who still have a recollection of how things were before the current situation of flow issues that have caused issues that we are discussing today around transfer of care - ramping, for want of the most appropriate word to use.

Today I want to speak about my thoughts on some of the causes of why the situation, especially - I'm mainly speaking specifically to the LGH today - my argument that the mismanagement of senior administrative staff and clinicians potentially have led to the problems that we are going to be talking about today.

I want to speak about the role of the former director of clinical services, Dr Peter Renshaw, and his role essentially for three decades in a senior role in the hospital, and concerns that not only has there potentially, at best, been mismanagement or maladministration, but at worst potential criminal activities that could have occurred, especially around the Coroner's Act 1995. I did put that in my submission initially, as an area that I wanted to maintain within confidential information to the committee, but today I want to make that information public, so I will be coming to that as part of my submission today, hopefully.

If I can briefly speak for a little bit longer, as I was explaining, I was really feeling like I was lucky to have graduated nursing in the early 2000s, and to be able to enter the profession and feel that I could be so supported by my peers and by the senior nursing staff. Despite being a mature-age student coming into a predominantly female profession, I felt I was so well-accepted and supported in the role, and I have become a good nurse because of that foundation that was given to me by the opportunities that were given to me by having such good support. I was able to work in a functioning emergency department.

Essentially, all our structures and systems have been put in place for an emergency department that would have flow. In practical essence, we should see peaks and troughs of demand in an emergency department over a 24-hour period. Historically, you would come onto a shift at 7 o'clock in the morning and you would have very few patients in the emergency department. The majority of the beds would be empty; the waiting room would be empty; and staff would have time to do appropriate checks and things that are required for the day. The early to mid-morning, obviously you would start to see an appearance of patients coming into the department, peaking to what could at times be very hectic times and a very busy work environment, where you would be transferring patients to the wards almost one after the other.

That's how it's meant to work, by trending down in acuity by the evening, and then by the beginning of the night shift, really you would only have true acute presentations, you know, someone's having a heart attack or a stroke. You don't get to choose what time of the day that is, but kids generally break their arm when they're playing football or netball or whatever. This is how all our structures of the system have been set in place, to deal with such a flow.

Unfortunately, after I then left the Launceston General Hospital and went to work in other hospitals and other community settings in the Northern Territory and returned in 2013 with my new wife and our first child to Launceston to settle down and come back to working at the General, things had changed, but things still functioned.

Things had increased in acuity, there were a lot more periods of time where there were blocks stopping the flow. That was when we sort of really began to see the beginnings of the occasional ramping issues, or prolonged stays of patients in the emergency department.

This then became really accentuated over the following years, especially in 2016 - we lost, I think, nine of our senior consultants. Michelle, you probably remember that. There was a mass walkout, essentially. Rosalie, I'm sure you remember. This was the beginning, where we started to really say, 'Well, hang on, things aren't working anymore. Things aren't properly - this is a crisis'.

We used that term 'crisis' back in the early to mid-teens of the - the process then just kept getting worse, the delays in flow. The emergency department would just become blocked, day in, day out. Patients would be admitted. They would stay there, and they would stay there for days sometimes. I remember a small child who was stuck in the emergency department for three days awaiting a bed - like, a child. It was absolutely, fundamentally absurd.

CHAIR - Eight years ago or something like that?

Mr MILLEN - Yes. So, this is a prolonged period of time ago. Around 2017, the Nursing & Midwifery Federation became quite involved in the case around the LGH emergency department. Having been a long-time member of the union, as most of my colleagues were, I became a workplace representative in 2018, primarily because I wanted to try to be a part of the solution. Potentially maybe a little bit naively, I went into the process thinking that it would be essentially a collaborative approach between the unions representing the workforce, and the public and the management, wanting to come to find solutions together. But unfortunately, the reality seemed to be quite the opposite.

My lived experience working through consultative meetings with management at different levels was that of almost gatekeepers, whether there was an implied or an inferred reason that they would not seem to want to get the reality of what's happening on the ground to senior levels of the hospital executive or the secretary or the minister. We found this absolutely gobsmacking. Some of you may remember that actually, as part of our industrial action in 2018, we created a vigil where staff, before their shift started in the afternoon, would come out onto the street and actually wave placards.

We were advocating that this is a crisis, that we are not being listened to by the at the time current executive. We were below her window, the chief operating officer, waving flags saying, 'Come and talk to us'. The absurdity of having State Service employees on the street trying to get an audience with their employer - it was madness. It absolutely seemed absurd to me.

The reason - this wasn't about money; this wasn't about anything except patient safety and the fact that we had seen such a deterioration in the quality of care that we could give. There is nothing more significant to someone in the caring profession than not being able to

provide a level of care that you would expect for your loved ones, for your parents or your children when they attend.

That level of anger, of why something is not being done about this at the time, brought us - and I thought we'd last a week or two weeks maximum, but we were on the street every day for six months actually, with placards. We have, as employees, endeavoured to bring a level of communal work with management to try to come to the table. We did get there through the Industrial Commission, but again, the fact that we are forced to go -

CHAIR - You never had the conversation in person?

Mr MILLEN - No, we never had the conversation, and that was the easiest thing.

CHAIR - Six months on the streets, and you had to go to the Industrial Commission, and you still never had a conversation?

Mr MILLEN - That is the absurdity. Part of the argument today is that the failings of the current health system lie in that structure that does not allow that level of transparency and accountability at levels of middle to upper levels of management that should be there. There should be a clear pathway, a clear way for staff on the ground who are experiencing these extreme workload conditions to be able to get that information to the people that need to be able to make these decisions.

CHAIR - Would you describe it as an extreme hierarchy that is resistant to hearing from people working on the coalface about the solutions and the conditions?

Mr MILLEN - That is exactly how I would describe it. Within the Launceston General Hospital's hierarchy, we saw the executive Director of Clinical Services for 30 years, Dr Peter Renshaw, have such a powerful position. The recent commission of inquiry, as you are all aware; I want to read a couple, so I don't misquote:

> Dr Renshaw's omissions and fabrications amount to misleading our Commission of Inquiry. We do not make this finding lightly. Misleading a commission of inquiry undermines public trust and confidence in the process. Such an act by a senior state servant is unethical and unprofessional and brings the State Service into disrepute.
>
> …
>
> Dr Renshaw had a responsibility to tell the Department and the hospital executive … that there had been a significant failure of systems and processes at the hospital resulting in a pedophile continuing to work in a pediatric ward for several more years.

CHAIR - How did you feel when you heard those words from the commission of inquiry, when you read them in their report?

Mr MILLEN - That has been the spark that has brought me here today. What came out in the commission of inquiry was so abhorrent. My words are irrelevant on that; but everything you take for granted in terms of what you would have expected from a hospital service - to care

for our most vulnerable people - and to know that there could have been things done that could have changed those outcomes for those people, that will have lifelong implications and will continue for generations to come, that potentially things could have been done to reduce the harm. That made me ask the obvious question of myself, 'What else is there?' This is one thing. The commission of inquiry has essentially scratched a sore and then to have the findings it has made.

CHAIR - They had a narrow task.

Mr MILLEN - They had a narrow task. Their terms of reference were very much directed to that very important aspect of ensuring the safety of our children in public places, but the Director of Clinical Services had such a role that he was at the tip of every pyramid in terms of a power paradigm.

One of his specific roles as the Director of Clinical Services, which seems a little bit mind boggling, for a long period he acted as the gatekeeper to the coroner. When someone passed away in the hospital, it would be he who had the final say on whether the case would go to the coroner. For a number of years there have been tearoom conversations about, 'Why did that case not go to the coroner?'

CHAIR - Are you talking about a person who has died in the hospital and conversations amongst staff?

Mr MILLEN - Amongst staff who had cared for that patient, who saw potential irregularities in the care, or the learning opportunities that come from it. Again, we can talk about the reporting, but those talks around the table were common and were not just dedicated to a few people.

CHAIR - When you say 'common', what sort of time frame are you talking about?

Mr MILLEN - I can recall four or five. I am not necessarily familiar with the patient, but I remember that discussion being held and even discussions with doctors. The commission of inquiry made me realise that this is something that needs to be investigated further.

I spoke with a colleague who no longer works in the emergency department but was a medical practitioner working in the emergency department. I have spoken to him before this meeting today and he has consented for me to give his name to your committee if you choose to accept it. He would be willing to come before you to speak to a case study of a specific incident where he, as the treating medical professional, has had a patient under his care die in the emergency department.

As I made clear in my submission, if a patient dies after having a medical procedure where they were not expected to die before the medical procedure, if there could be a potential that that medical procedure led to their death, then that should be forwarded to the coroner.

As far as he saw it - black and white case. This has to go to the coroner. He attempted to speak to the coroner himself. When making the call, instead of being transferred to the coroner - I will let him explain the situation in detail himself so I don't misspeak.

CHAIR - We won't get you to speak his name at the moment; he can contact the inquiry. We would like to hear from him if he wants to speak to us.

Do you have in your memory a specific case? Can you talk through the process that you think might have been going on in these four or five cases? Can you remember any case or situation and what might or might not have happened in the case? You are alleging the involvement of Dr Peter Renshaw in these cases?

Mr MILLEN - Correct. The one that's foremost in my memory, and I need to be very careful not to disclose any patient confidentiality.

CHAIR - It is also important that recognising that there might be family who don't wish to be named. Just talk in generalities, if that is possible.

Mr MILLEN - There is the desire to talk about specific cases because it has more merit.

Ms O'BYRNE - We have the capacity to hear evidence in camera. I am conscious that we don't want to put Tom in a position that compromises him if he's straight into identifiable information.

Mr MILLEN - Yes, I'd probably appreciate that, Michelle, thank you.

Ms O'BYRNE - I think that might be a better way of doing it, Chair, just to make sure that Tom is safer in this process. Also, because there may be people who, for reasons, could find this quite traumatic to hear.

Mr MILLEN - Yes, and I think that's the most - at the forefront, has to be the thoughts of the people involved in the process. If you've lost a loved one, that could bring up all sorts of trauma and even speaking in generality, so I think it's best if I -

Ms O'BYRNE - It might be possible for you, at the end of doing that, to be able to comfortably say, 'This is the bit that I'm happy to be on the record, but these bits I'd need permission from - '. Sorry, Chair, to interrupt.

CHAIR - Yes, I hear what you're saying. We can go in camera to talk about that in detail. Before we go in camera, just to be clear for people who are watching, what you're describing are a range of things, which are a range of situations that happened over multiple occurrences. What you're telling us is that there was Dr Peter Renshaw who was in charge at the time. What happened? What was his role?

Mr MILLEN - His role would be to sign a death certificate that would mean that the cause of death was a known cause of death, and then not submit it to a coroner as per the Coroners Act 1995.

CHAIR - What you're saying is that we don't need to go into the cause of the death, but a death where - presuming - a clinical professional or a nurse would have identified that there ought to have been a coronial investigation into the intervention or the circumstances of the death, they would report that case to Dr Peter Renshaw? Is that what would've happened?

Mr MILLEN - Correct.

CHAIR - Then, normally, what would need to happen, under the Coroners Act, is that Dr Peter Renshaw would then advise the coroner that that investigation needed to -

Mr MILLEN - He would have a discussion with the Coroner's Office, and they would determine whether there should be a coronial investigation into a death.

CHAIR - What you're saying is that Dr Peter Renshaw interfered in that process? How would describe what happened?

Mr MILLEN - Well, the legislation is clear. If a person dies in a facility where, as per the act states succinctly, under certain criteria, it needs to be referred to the Coroners Act. What I'm saying is that in this case where the doctor is willing to come and speak to you, he can clearly show you how that has been the step of then referring to the coroner has been blocked, despite the doctor wanting to make this submission to the coroner himself.

CHAIR - The doctor who was in charge in the ward, the clinical doctor at the time, and it's Dr Peter Renshaw who you're saying was the person who obstructed the process.

Mr MILLEN - Correct.

CHAIR - Has this occurred on multiple instances to your recollection?

Mr MILLEN - Look, I won't say that now because I don't have the details of such an allegation. But I will succinctly talk about this specific allegation which I am raising today.

CHAIR - Previously, you said in conversations in the staff room, there were conversations about concerns.

Mr MILLEN - Absolutely, and his role is - so the process would be: when a person dies in the hospital, there would either be a known cause of death, in which case they would not need to go to the coroner and the doctor, or Dr Renshaw himself, would sign a death certificate. But, in cases where, under the Coroners Act - that says which cases need to be forwarded to the coroner - the treating doctor would tell Dr Renshaw that this case - they would assume - should go to the coroner. Dr Renshaw would be the person to then submit that case to the coroner.

My question is: where is the accountability over his role as gatekeeper of that very important information? And with what I am alleging today, and with the past experience of the commission of inquiry, raises questions that I think need to be further investigated.

CHAIR - Before we go in camera, were any complaints made higher up about the situation you are describing?

Mr MILLEN - I am not aware of that. What is our time? I apologise, I know I have been speaking the whole time. This is such a broad issue, and I really think it is important I speak, if it is okay with the committee. In my submission, I really spoke around escalation policy, and again, the very pointy end of the escalation policy was Dr Renshaw after hours, his role in ensuring, when crisis points were happening that stopped flow.

I am assuming you are aware that at the Launceston General they have a traffic light system in terms of escalation. Green is everything is okay, orange is things are getting busy, and red is an acute situation that we need to work on and immediately address. As the Auditor-General's report in 2019 stated clearly, essentially the level of escalation at the LGH has been red for the majority of the last two years. By essence, the plan is failing the staff and the patients in the hospital.

Often, we would be at red escalation and the medical officer in charge of the department would be calling Dr Renshaw, and I remember just asking them, 'The response you got?', and it was a shrug of the shoulders and, 'Keep on doing what you are doing'.

CHAIR - How did that make staff feel?

Mr MILLEN - Absolutely gutted. Absolutely gutted. I remember one day some peaches arrived, and it was like, 'What's this?' and it was, you know, 'That's because you guys are under the pump', and it is like, 'Oh my goodness, the disrespect'. There are people, potentially their lives are at stake, when there is an elderly person in pain, or a child screaming, and you do not have a clinical space, and as previous coroners have reported, the instance when there is no flow, the medical officers and the nurses cannot do their job. You become almost numb. 'There is someone in a chair, they can't be too bad', they are having a heart attack. This is the reality on the ground for the staff.

I speak to a failing of the escalation plan. I speak to a system, a culture, which was also brought up by the Auditor-General in his report in 2019, a culture of management that lacked transparency, and I would argue up until when I left. There are changes happening, and I acknowledge that, and wanting good things to come from now. But it is important that we look back at what has happened over the last period of time, so that we can learn from the mistakes that have been made. But before we can learn from the mistakes that have been made, we need to acknowledge the mistakes.

I think the culture, even from you as legislators, you have the power to lead this debate now. Under the State Service Act, I have been threatened prior. By speaking about these instances, the tool that is utilised by management is to threaten your employment, your livelihood. How can we as a community hope that we get the correct answers if the light of democracy is not shone upon the structures within our own democracy. I want to read one last thing, I know I'm on a bit of a roll at the moment, I apologise, but the State Service Act, the Code of Conduct:

> An employee must at all times behave in a way that does not adversely affect the integrity and good reputation of the State Service.

What happens if the State Service isn't functioning as it should? Where is the avenue for a whistleblower or for someone to speak. These aren't about incidental events or Facebook posts; this is about significant and serious potential breaches of the law.

CHAIR - What you're talking about is six months standing outside your hospital trying to have a conversation with management and never getting that. You're talking about a situation which is at 'red escalated' so that people are having heart attacks in chairs, and you're not able to deal with the situation and management is shrugging and walking away. Just to be clear, in relation to Dr Renshaw, you're alleging a specific case that you will speak to us about

in detail later, that Dr Renshaw filled out a death certificate in a misleading way and prevented a matter from going to the coroner, despite the fact that he was required to do that by law?

Mr MILLEN - That is correct.

CHAIR - It's obvious that is a lawful step that should have happened that has an impact on the hospital's reputation. Can you describe for us the impact it had on staff who were concerned about a range of instances where they didn't think lawful actions were taken?

Mr MILLEN - What is important to note is that a system that allows someone to be in their role for 30 years, with a significant amount of power, without an element of oversight that would be given under any other. I'm sure you are accountable to the people every few years. These roles, as the commission of inquiry clearly noted, this information wasn't flowing to the secretary, and I'm assuming not to the minister. It does not fill staff with hope that they can look for the solutions within the current structures that we have, and when we look at the broader structures that they, in themselves, inhibit the telling of truth.

CHAIR - Why do you think Dr Renshaw might have taken the actions that you allege? What possible reason?

Mr MILLEN - I would argue that it is the system that has allowed that to occur. It's not an individual. Humans are humans, we are all fallible, we all make mistakes, we all make errors, and I am the first to put my hand up about that. But, when you have a system that allows that to occur in a democratic state - this is not Cuba or China, this is Australia, we are proud of our democratic principles. Unfortunately, it is the minister of the day. I appreciate there are members of all political parties here and I think it's great, but you really need the Minister for Health at this table.

My concerns about how middle management worked at the LGH and about adversarial discussions - we need to come together on finding solutions. That's a discussion for another day; but staff want help, staff want hope, and we want leadership from our politicians to provide that and coming out with a message of unity, where we are able to acknowledge that this goes beyond any political discussion. I believe every single politician in this place is here with the good intention of making our state a better place.

CHAIR - That's right, we all are. That's why we're on this committee.

Mr MILLEN - I guess I'm putting it back onto you guys, what do we do from here?

CHAIR - Tom, I know that Simon wanted to ask a question and then Michelle.

Mr BEHRAKIS - Thank you. Your contribution was a great segue into that. Dr Woodruff mentioned the why, and we spoke a lot about Dr Renshaw, but as far as the cultural issues in the health sector - and you're definitely not the first one to bring that up - what could possibly motivate that sort of gatekeeping and that adversarial culture in a system where I would have - maybe naively - assumed that everybody would like to solve the issue of access block and everybody would like their health system to work better? If we want to get to the root of the problem, what would be motivating that sort of culture?

Mr MILLEN - You would probably need to look at the budgetary office and who has the hands on the cash. There is undoubtedly pressure on public servants to maintain their budgets and not to ask for more and more. You know, it's just common sense. I don't know, but when you don't have that accountability within that system and potentially a limit of terms of some of these roles, you can - power, you know, I'm not alleging corruption here, but power corrupts and total power corrupts totally, as we know. So, in terms of how do we fix the system, let's start by getting a big broom and looking and seeing are we doing everything according to appropriate governance?

CHAIR - And the law.

Mr MILLEN - And the law.

CHAIR - Thank you, Tom. Michelle, you've been waiting patiently.

Ms O'BYRNE - I know and I've kind of missed a little bit in terms of the timing of it now. Tom, this is going to sound a little bit inane, given some of the broader systemic issues that you've raised, but can I go back to the escalation policies again? Do you have a moment still to chat about that?

Mr MILLEN - Of course.

Ms O'BYRNE - We had some people suggest that one of the issues is that the escalations aren't called early enough - so that by the time the escalation is at red, it's been red for quite some time and there's nowhere to move. You've worked in ED for years and you know the system well. How would you see an escalation process that worked? What would it need to have in place to deliver the type of support that ED needs to transition people into beds?

Mr MILLEN - We just need a plumber. When the pipes block, we need to unblock the pipe. The emergency department, when it fills up with admitted patients with nowhere to go, that is where the bottleneck is. In emergency departments, best practice is a patient should present, get an assessment, get a diagnosis, get treated and either be back home within four hours or admitted into a bed and then sent to a ward. That is how I discussed at the beginning the process used to work.

In terms of escalation, what do we need to do to get beds? Now, there is no silver bullet, as you all are aware, but I would look at some basic things. I don't know, it's amazing, because most of our colleagues now in the hospital or in the emergency department at least are locums. Thankfully, the locums have saved us. When I started my career, it was unheard of that you would have a locum in the emergency department, even in 2017, never. Today, if you look at the roster, almost half of the staff are locum nurses.

CHAIR - Is that because the system is so extreme?

Mr MILLEN - I'm the classic example. I should have, when I started my career in the ED, I thought that was where I would end my career. I love it; but we've lost so many skilled practitioners that now we are at a super crisis where we don't have the people on the ground. Just looking at the proposed policy for ambulance offloading after 60 minutes, it will get the paramedics back on the road, but it's going to cause absolute chaos in the emergency department. It will mean there will be more patients who are lost, and you will get adverse

outcomes, and we know what the adverse outcomes means in our field. If it was as easy as just saying, 'do that', then it would have been done a long time ago.

CHAIR - And yet, there are a lot of micro issues that can be done to improve patient flow.

Mr MILLEN - Of course we can. We need to acknowledge what has already been done and the fact that we have patient flow now in the hospital. It is getting better, but unfortunately, it's glacial in its movement forward and we need a rapid change, a transformation. To your question, do we need to delay some planned surgical interventions? Of course, that sets us back, but we have to think of that person on the ramp or in the waiting room of the emergency department, they don't have a diagnosis.

When I first got into trouble for speaking out of school, we are talking with the *Four Corners'* report and the gentleman, Mr Novaski, he passed away and the fact that I was threatened, in essence, with consequences for speaking about the current state of the department. This was six years ago.

We need to move. We don't need a bigger emergency department. There are enough beds if we had flow. We need to get people through. How does that look? What can we do? There are lots of things that we could do. I was listening to the end of the previous witness.

CHAIR - Dr Paul Scott.

Mr MILLEN - Dr Paul Scott. Talking about increasing the scope of practice of our already existing practitioners. We have paramedics who could be amazing doctors if they wanted to be, but they choose to be paramedics because it is a wonderful profession. If we gave them a broader scope of practice to potentially treat people in a way, have a medical officer on a Zoom or a Teams call, these guys are amazing. They are the most skilled. If I want to get an ECG interpreted, I go to the paramedics because they are amazing, and we are under-utilising them. We could be getting them to do more out of the hospital, to keeping people, but we constrain them by such scope.

As for nurses, when I worked in the Northern Territory, I was suturing people. The scope was much broader. By returning to Tasmania, often I have been instructing a junior doctor to stitch someone up for the first time, whereas I have done it dozens of times. For a start, as Dr Scott said, we could think about changing that medical model a little bit, which makes its own issues, I know, but giving more empowerment to nurses and paramedics and allied health and to acknowledge their skill sets and pay them appropriately. It is a lot cheaper. Save our hospitals for those people who are having acute crisis medical. We all have parents or children and when something terrible happens, we want them to get that care that is needed at that time, but at the moment, you can't guarantee that. That is one of the main reasons why I had to say I have had enough.

CHAIR - Yes, too stressful. I am looking at the time and unfortunately, we need to save some time to go in camera to hear the details that you will tell us there. Before we do that, you have given us some important and disturbing information - allegations made against Dr Peter Renshaw and a failure to adhere to the law, the Coroner's Act. What steps do you think should happen next?

Mr MILLEN - I don't know. I am leaving that up to you guys.

CHAIR - Have you had conversations with any former colleagues? Are there other people who, you have mentioned one person, who have also experienced this and whether they have any views on steps that should be taken? An investigation perhaps?

Mr MILLEN - It has been said to me that if this is legitimate, we can't assume anyone is guilty or not guilty of any incident. All I am calling for is an inquiry into whether an illegal act occurred. If not, then that's fine, but if so, then the normal courses of justice should prevail. We should not assume guilt before it's been given.

CHAIR - Okay. Was there a specific year or range of years that your memory takes you back to?

Mr MILLEN - The preceeding four or five years.

CHAIR - In recent years.

Committee, I think we might finish the open part and move in camera.

The Committee suspended at 10.50 a.m.

The Committee resumed at 12.01 p.m.

CHAIR - Welcome, Katie. Thank you for attending the committee session today. Before we start, did you receive the guide from the committee secretary, outlining that this is a parliament committee and you are covered by parliamentary privilege while you are here, which means that gives you the freedom to be able to say what you want and not be in any fear of being sued or any other court action. That privilege doesn't follow you outside and so it is something to bear in mind if you mention things outside that could leave you open to some sort of court action. It is a public hearing today and so there will likely be members of the public and possibly journalists online who are watching. Is that all clear?

Ms HAYES - That is clear.

Ms KATIE HAYES, BRANCH COMMITTEE MEMBER AND PHARMACIST, THE PHARMACY GUILD OF AUSTRALIA, MADE THE DECLARATION AND WAS EXAMINED.

CHAIR - Katie, you're representing the Tasmanian Branch of the Pharmacy Guild of Australia?

Ms HAYES - I am, yes.

CHAIR - Did you want to make some opening comments or a statement? We have your submission.

Ms HAYES - Yes, I'll make a statement.

Good afternoon, Chair and members of the committee. The Pharmacy Guild of Australia welcomes the opportunity to contribute to discussions on transfer-of-care delays, ambulance ramping. In Tasmania, there are over 160 community pharmacies of which about 80 per cent are members of the Pharmacy Guild. Community pharmacists play an integral role in health care across Australia, being the most visited and accessible health professionals in the country, with close to 460 million individual patient visits per year. Pharmacies are distributed equitably across the country and are often open after hours. There are 333 suburbs and locations across Australia that have no GP but have at least one community pharmacist.

Health affects everyone. We all have a level of health and expectation of what our health should be and what our access to health service and care should be. At the most acute and urgent times in our health journey, the expectation is that we can access care immediately. Ambulance ramping prevents timely access to health care and the hospital system, which will require a multifaceted approach to achieve the expectations of Tasmanians.

There are a number of contributions that community pharmacists can make in addition to what we are already undertaking that can assist in reducing the pressure on transfer of care. This is particularly important, understanding that our population is on average older than other state and the difficulty in accessing general practitioner appointments from an availability, distance and a financial point of view.

We understand that at times there are complexities with community pharmacy in terms of legislation, that being state and federal. Also the remuneration that we receive comes from

different places, such as federal government, sometimes state government, from the consumer and occasionally through private health funds. Another complexity is that we are mainly delivering a service which is a federal service - that is, a PBS service. However, we don't believe that complexity should be a barrier to Tasmanians accessing timely and appropriate health care.

We know that patients have better health outcomes when they have a number of health professionals in their team. Of course, pharmacists are no exception to that. Practising to full scope has been the aim of pharmacists for many years. We've made a few steps across that journey, particularly with vaccination and also with protocol prescribing - that's prescribing within a set guideline. It's happening in other states and is very soon to arrive in Tasmania for urinary tract infection. However, there's much room for a pharmacist to contribute in reducing presentations to emergency and reducing hospital admission.

Throughout the uncertainties of the COVID-19 pandemic, pharmacists were able to supply one month of medication for any medicine listed on the PBS where we considered that this was reasonable and safe, where a patient was unable to get to their GP in enough time so that they didn't run out of medicines. After a couple of years this list was pared back, and we now have a couple of handfuls of medicines available that we can do this with, but that is it.

Recently, Tasmanian legislation was changed so that we could supply some more of the medicines that were previously on the list, but they are not subsidised on the PBS so for some patients this means that it is financially unavailable for them. We are thinking of things like asthma inhalers or anti-coagulants where they might be $60 or $70 for one month's supply, so clearly financially inaccessible for someone who perhaps has a concession card.

While the state can't change the PBS listing, they can certainly put pressure on the federal government to enable this list to be expanded so that patients don't have a cost barrier. When we think about the consequences of patients not taking medicines such as an asthma medicine, even after a few hours they can become short of breath and their condition can deteriorate and then we see them going to urgent care or emergency and having impairment of quality of life.

Another example is when a specific medicine becomes unavailable, pharmacists can do nothing to help the patient. They must refer them back to the GP. Think of the accessibility issues - it might be two weeks or more before they can see a GP, meaning that they go without medication for that period of time unless we can slip them in somewhere else into urgent care. We don't want to send them to emergency. Once again, a patient not taking medication is much more likely to present to emergency, perhaps blocking the system or even requiring an ambulance to get there.

There is a host of screening and risk assessment activities that pharmacists can and do undertake. For example, cardiovascular risk assessment, where the pharmacist measures a number of potential contributors to cardiovascular disease and assesses risk, followed by advice and referral where necessary. While this is generally a user-pays service - pharmacists aren't funded for these activities - it is not necessarily financially accessible to everyone. Those who are most likely to need it probably can't afford it. When we think of our socio-economically disadvantaged communities, they are unfortunately not going to be able to afford a $50 service. We know that early intervention in cardiovascular disease and pretty much all health conditions provides the best opportunity of preventing complications.

Imagine if we had a service that we can reduce the risk of somebody having a heart attack being their first presentation to emergency. If we are reducing the number of people who have those complications, we are not only preventing blocking within the hospital system but improving people's quality of life.

We can take this a bit further and we can look into managing a health condition once it is diagnosed. Pharmacists are well trained to monitor. We have good knowledge about the medicines and we don't currently have any ability to be able to adjust patients' medications. In an ideal service a patient would be diagnosed with something like hypertension, we would review the patient, have a look at their medicines and adjust medicines where appropriate. We know that poorly controlled hypertension increases the risk of stroke, which is an emergency. People need transport to hospital and there is potential for ongoing disability and impaired quality of life.

Pharmacists are well aware of the need for timely and appropriate communication with other health professionals. I know that this is a concern of other health bodies, but we have already established professional pathways to do this. However, an investment into this area is welcomed; it would ensure that transitions of care would be more seamless than they currently are and it would improve patient safety and efficiency.

There are other examples where Tasmanian pharmacists have taken the opportunity to practice closer to full scope and improve and maintain the health of Tasmanians, including things such as long-acting injectable buprenorphine. This is therapy used to for people with drug dependence. Access through community pharmacy, which has recently occurred, has improved patient stability, and it stops patients needing to access public systems which are in very few locations.

We also have the National Immunisation Program, which has commenced this month. We are looking at preventing disease such as pneumonia - another cause of people going to hospital - and also supply of naloxone, which is used to treat opioid overdose, both in prescribed and illicit environments. This medicine is given to people who are at risk of overdose and to their family and friends, all at no charge. It's a lifesaving treatment. It buys us time to get people the care that they need; it stops people dying.

Community pharmacies are particularly invested in their communities, often knowing what the needs are. We're very enthusiastic about helping people with their health. We welcome ongoing opportunities to contribute to increasing timely and appropriate health care across Tasmania.

CHAIR - Thank you, Katie. That's a very welcome overview of the situation. You mentioned patients needing medications who can't get them can sometimes end up going to the emergency department to get them. Can you expand on that comment?

Ms HAYES - For sure. I mentioned asthma and cardiovascular disease in particular. If a patient is taking an anticoagulant or anti-thrombotic medicine, which means we're trying to reduce the risk usually of a stroke or some other clotting disease, if they don't take that medicine, these medicines have a reduced effect very, very quickly. For a patient in that situation, they may present to emergency because they've become symptomatic or because they know the extreme risk of not taking that medicine and hoping to seek the medicine itself.

CHAIR - Do you have any - that's quite plausible, I'm sure - data on this? Do you have any evidence or information you could provide the committee about how often this might happen?

Ms HAYES - It's difficult to obtain specific information in regards to when people have just run out of medicines. But there is quite a large number of people that present for exacerbations of chronic disease. So there are often medication-related problems, and that can be non-adherence, which would be classed as non-adherence, but I can't give you a specific number or the proportion of people who that happens to.

CHAIR - So you're speaking in general terms or from things that you've heard in Tasmania?

Ms HAYES - Things that we know that we experience day to day as health practioners, understanding that our patients often come back to us because of non-adherence in that they haven't taken their medicines.

CHAIR - There are only so many things you can do to help people in that situation. That's tricky. What about the relationship between GPs and - is a small part of the issue of preventing people from ending up in that situation, having to go to emergency, the GP being able to prescribe for longer rather than having to go and get repeat scripts? That has happened, hasn't it, in some areas? The federal government brought in some changes there, and so people are able to get longer script fills.

Ms HAYES - That is a part of it. In regards to - I think you're referring to 60-day dispensing, so for some medicines they can potentially have a 12-month supply of medications when they use up their repeats. A lot of GPs understandably want to see their patients more frequently, because the condition that they have requires ongoing monitoring more regularly than that, such as with cardiovascular disease or diabetes. There is some understandable reluctance from GPs to prescribe those. Also, the flip side of that is if a patient is only presenting to the pharmacy every two months, then we have no eye across them in what's happening to them for 60 days, and we're often the ones that tend to know them better, know them day to day, understand their family circumstances. If we're not seeing them for two months, that makes that monitoring a bit challenging as well.

CHAIR - Can you talk about how you do monitoring? My experience of going into a pharmacist is that it's - I suppose I haven't experienced that sort of monitoring. I just turn up, get a script filled, wait in line. I know in some areas where you're lucky enough to have a relationship with the pharmacist, you might have a longer conversation. But, wouldn't it be typically the case that it's really about - I mean, how does this monitoring work in your experience?

Ms HAYES - Yes, of course there are different levels of care in different practices. For most of us, we strive to assess people every time they come in, so a big questioning about how their medicine is going, checking for adverse effects, asking when their symptoms were last monitored. That might be blood pressure, popping them over to get their blood pressure checked if that's necessary, and just working through those sorts of things. A lot of the time, there isn't an issue but it does provide the flexibility that we can check in with them and pick up - intervene - when necessary.

CHAIR - You talked about pharmacies being able to manage health conditions once diagnosed. This is sort of an area, I suppose, that you are already doing or would like to be able to do more of?

Ms HAYES - I guess, to an extent we're doing a little bit of, but we have no ability to change a medicine, so we can't adjust the dose up or down. We can only refer back to the GP which is - you know, that's fine. Of course, we would do that, but it's also not paid so you've got to find time to give that to the patient outside of the dispensing process.

CHAIR - So, you would be proposing a model that would get paid for?

Ms HAYES - Absolutely.

CHAIR - Where would that payment come from? Would that be a state or federal -

Ms HAYES - It could be either. It also could be through private health insurers as well. If it were to be a federally funded program, we would ask the state to support us and advocate for us to introduce these programs. There's absolutely no reason why it couldn't be a state program that the state could run a pilot to have these programs within pharmacy and collect data and see what difference that makes.

CHAIR - I suppose there would be competing models for looking at providing that expertise for patients, wouldn't there, like nurse practitioners, or extended-care paramedics, or -

Ms HAYES - Absolutely, but we're also not against those professionals undertaking those programs. I think that's important in scope, that we're all - all health professionals should be practising to full scope, and that scope will overlap. That's fine, because it means that Tasmanians can access what they need when they need it.

CHAIR - Michelle, Anita or Simon, have you got some questions?

Ms O'BYRNE - I wanted to ask, if you're extending scope of practice and doing more of this consultation work, what are the staffing implications?

Ms HAYES - Staffing implications, was that?

Ms O'BYRNE - Yes. So, I think we talk to most pharmacies at the moment and they're struggling to get pharmacists. Are we looking at skill shortages or staffing resourcing issues in order to meet some of these opportunities? I absolutely support pharmacists doing more. I think we under-utilise them a lot, but I do know that there are a number of pharmacies that are struggling for pharmacist staff.

Ms HAYES - Yes, you are absolutely right. There are some complexities around that, but there's also opportunity to upskill some staff, so that might be highly advanced students, for instance, doing things. If we have a patient who has a wound and we're doing some wound care, that they're trained enough that the pharmacist comes in and provides opinion and that staff member can undertake the actual application of that service.

But also, we spend an awful lot of the time trying to get people into the services that they need. So, all of a sudden, we would gain that time back and actually be able to provide that

service, and it would be much more timely. We wouldn't send people off into the world knowing that they're probably not going to access those services anyway.

Ms O'BYRNE - I may have missed it before when you were talking about trying to get people to the right level of care. Do you keep data on how many times ambulances are called to pharmacies?

Ms HAYES - No, and I know that because we've called several and we've never told anybody that's what we did.

Ms O'BYRNE - Yes, but I've spoken to other pharmacies who have said that they've had people come in who are so ill that they have had to call an ambulance because they haven't been able to access any other care mechanism. This would be an interesting bit of work to understand the level of complexity that it's presenting.

Ms HAYES - You make a good point about needing to call ambulances, like we've had on a number of occasions where someone's looking very unwell or presenting very poorly and we will call the GP practice to try to get them in. It's just not feasible. They can't. They can't fit the people in, and I completely understand that. You can't make room where there's no room. We have to send them to a hospital.

Mr BEHRAKIS - When you talk about the overlapping of scope, that would be something that's not necessarily a bug but a feature, and like a bit of redundancy when people need certain services and they can't get it from a GP, being able to get it from a pharmacist or from other areas in the health sector. That would be a beneficial feature of what you are suggesting?

Ms HAYES - Absolutely. If the patient is there in front of you and you can provide that care, that's when they are most likely to receive that care.

CHAIR - Can you talk about the difference between community pharmacies and - for the people who are watching - what do you mean by community pharmacies?

Ms HAYES - A community pharmacy being a pharmacy with a location that you can attend out in the community, as opposed to someone who works in the hospital system perhaps, and also academia.

CHAIR - Thank you. I don't know if you're able to speak to this, but one of the issues which has been raised in the inquiry, and which the Government is now looking into, is providing services and particularly opportunities for diagnostic and therapeutic interventions across seven days of the week. That would mean the possibility of people being able to be discharged on the weekend. They would need to have medications and they would need to have a relationship between the hospital discharge and the pharmacist to get their medications.

Do you have anything to provide the committee about what you think the role of pharmacists should be in making the process of discharge easier and reducing the risk of people going and having a gap where they don't have medication for a period of time because they haven't been able to get to a pharmacist in the area, or those sorts of gaps?

Ms HAYES - Currently the practice is that the pharmacist working in the hospital will usually contact the patient's community pharmacy, first to confirm the medicines that they take, and then just to let the pharmacy know that that patient is in hospital and is there anything else we'd like to contribute.

On the other end of that, when the patient is being discharged, the pharmacist will send us the information that's required in terms of any medication updates, and to let us know whether we need to supply medicines immediately or what the scenario will be on the weekends. For us, at my pharmacy, we are closed after Saturday afternoon. The patient will receive a small amount of medication from the hospital until they can comfortably access the pharmacy. The pharmacists at the hospital are excellent. They are probably the most timely communicators within the system, and we are often sharing that information with the patient's GPs because it comes to us faster than what the patient can access from the GP.

CHAIR - Does the pharmacist in the hospital give the information to the patient's GP as well?

Ms HAYES - No, that information comes from a discharge summary, so more through the medical units rather than the pharmacy.

CHAIR - But the same information about the medications and all that stuff will go to the GP, and the pharmacist in the hospital speaks to the pharmacist in the community.

Ms HAYES - That's right.

CHAIR - You said, 'This usually happens'. Why doesn't it always happen? Is there a protocol that guides this to make sure it always happens when it's required? I assume some people could be discharged from hospital and they don't need any medications - joy for them, but that's probably a small proportion.

Ms HAYES - I can't speak to that because I'm not aware of what the systems are within the hospital system, but I understand that as much coverage as the hospitals can provide, they do. There would definitely be patients that slip through the cracks, particularly if it's a very short admission. But yes, someone from one of the hospitals would need to provide you more information on that.

CHAIR - Would you support, as a community pharmacist, this process being formalised so that there are no gaps that people slip through, and if there is a requirement for a person to take medication when they leave the hospital, that there be a conversation with a GP and then with the local pharmacist. The patient would need to be involved in that conversation.

Ms HAYES - Absolutely. We are very much encouraging a patient being at the centre of care, and as I refer to, improving those communication channels, so that it is timely and instant, and that all the health professionals in that team are receiving the same information, and that each patient gets the same care in the hospital system as well.

CHAIR - Very good. Do members have any issues?

Ms DOW - A question about the scope of practice review. There are recommendations that the Government has already agreed to implement. As far as the Pharmacy Guild goes, what are your next key priorities from that work that you would like to see implemented?

Ms HAYES - It could be an endless list. I have just written a few down.

Ms DOW - If you were to prioritise the top three or four.

Ms HAYES - Urinary tract infection treatment is coming, and so similar types of disease management or acute episodes of care that we can manage. Shingles is an excellent example. It is very easy to diagnose someone with shingles. I remember about 12 months ago diagnosing someone without even seeing them, from what they were saying, and came and had a look. She had to wait 24 hours before she could access her GP, which was really fast. If we do not get this treated within 72 hours, the risk of complications increases substantially.

It is this acute management - under protocol that is fine, we are very good at sticking to guidelines. So, asthma flares; shingles; maybe chlamydia screenings and treatments; we will be doing urinary tract infections; those types of things. The others are probably fairly equal in terms of screening for conditions and managing conditions. Perhaps an easy one is the change of PBS listing to allow continuance of medications. That is probably an easy one for state and federal governments to work out together to enable that to happen.

Mr BEHRAKIS - On the importance of that relationship and the communication through the hospital to community pharmacies, and the benefit of relationships between the community pharmacies and patients: Dr Woodruff touched on the experience of many people, including me, of going to a pharmacy and sometimes it is more a retail experience than a care experience. As far as the difference between - without naming any names - the more corporate-style pharmacist versus the more community pharmacy: in that they are a smaller business and you might have more likelihood of having relationships with the customers that come in. How does that impact not just on the relationship and the treatment of regular patients, but when patients are coming out of hospitals, having a pharmacist that has the ability to have relationships? When you have those big corporate chains, they work almost more like a supermarket for medicine rather than an place that is offering ongoing care. How does that differ?

Ms HAYES - You are right that when you have a model that is about service and care, that the patient is more likely to receive that service and care. I can give you an example from our practice. One of our very good patients was admitted to hospital and discharged from hospital on a weekend - perhaps a good example - and provided with enough medicine to get through the weekend. She rang up on Monday morning very distressed and she did not know what to do, so I sent my pharmacist up the road to see her. He sorted it, and she was fine. That is the level of service that we try to provide where we can. It's not funded, but it will work itself out, and we hope to get funding down the track. As community pharmacists, as Pharmacy Guild members, we want to provide that service. That is what we are after - health care, not retail.

Mr BEHRAKIS - As a follow up, you mentioned earlier that sometimes when you have regular patients, you notice something changing and you notice sometimes there needs to be an intervention. I get regular medication, but it's a different pharmacist that I'm speaking to every time I'm getting scripts filled. How important is that, for anyone who might be listening

and for our benefit - having a pharmacist where you have a relationship versus the more bulk retail-style pharmacist?

Ms HAYES - I couldn't endorse that more. You would be pretty fortunate to see the exact same person all the time, but you would only see two or three people if you attend a pharmacy regularly with a more community feel. We are pretty good at note taking and recording of information, and if a patient was saying something we should follow up on next time, the note makes sure it is followed up. Wherever the pharmacy is, we encourage people to stick with that one pharmacy and have a relationship with all the staff in the pharmacy - the pharmacy assistants, the techs and the pharmacists.

CHAIR - There is no distinction between the smaller community pharmacists and those big bulk retail ones though, is there? They are different business models.

Ms HAYES - Different models, yes, and there isn't any reason why some of the bigger pharmacies can't provide these services. They absolutely can. You look at what the focus is of that business. You can be any banner, any number of staff, any size and still provide the same service; you've just got to provide that service.

Ms O'BYRNE - One of the concerns raised a lot is the small number of people who now have a regular GP where they have an ongoing relationship. Having a dedicated GP who they can get to all the time is diminishing. Have you had a noticeable difference in how people present with medications because they are seeing different doctors more regularly, or does that make no impact on the type of additional information and support and relationship that you provide?

Ms HAYES - I can't say it makes no difference. I would say it has some impact depending on the patient's health literacy. When they get used to a certain GP and then they see a different one, then sometimes the communication styles can be different. When you are in that setting at that acute time, it is hard to take in all of that information. Having rapport and understanding - the patient understanding the professional and the health professional understanding the patient - can have an impact on condition management and understanding of treatment. But that is hopefully where their pharmacist will pick up if there are any issues they can smooth out and make sure the patient is doing what they are meant to.

CHAIR - That's all the questions we've got; is there anything else you would like to say to the committee or other evidence, last words, thoughts for the report?

Ms HAYES - No, just that as community pharmacists we are keen to be able to improve and deliver more health care to patients in Tasmania, so that we are not seeing people disadvantaged for any reason.

CHAIR - We'd all agree with that. Thanks very much, Katie. Just before you leave, can I remind you that today is covered by parliamentary privilege in this committee's proceedings, and when you leave any comments that you would make that could be defamatory or end up in some sort of court action are not covered by parliamentary privilege.

THE WITNESS WITHDREW.

The committee suspended at 12.34 p.m.

The Committee resumed at 2.05 p.m.

CHAIR - Welcome. Online we have Anita Dow and Simon Wood, who are members of parliament from the north, and Simon Behrakis and me. Simon is from Clark and I'm from Franklin, seats in the south, which means nothing to you, Hamish.

Welcome. Thank you very much for appearing today. Before we start, have you read the information that the secretary of the committee sent, which is about the parliamentary privilege that you are given when you make statements to this committee of parliament? The purpose of that is that so you can be full and frank in your comments and not fear any repercussions or defamation or court action as a result of what you say, because we want the best possible information so we can make the best possible recommendations to parliament about how we should respond to the situation of ambulance ramping in Tasmania. All clear?

Dr ASCENCIO-LANE - All clear.

Mr BOURNE - Yes.

CHAIR - This is now broadcast, and people from the public and journalists might be watching, so if you could say your name and title and read the statement in front of you, please.

Dr JUAN CARLOS ASCENCIO-LANE, AUSTRALASIAN COLLEGE OF EMERGENCY MEDICINE, TASMANIAN CHAIR and **Mr HAMISH BOURNE**, POLICY LEAD, AUSTRALIASIAN COLLEGE OF EMERGENCY MEDICINE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. Would you like to start with some opening comments?

Dr ASCENCIO-LANE - By way of an introduction again, my name is Juan Carlos. As well as working as an emergency physician at the Royal Hobart Hospital, I hold the title of faculty chair for the Tasmanian board, but also work as a director for the EMET program which is providing education to the rural areas down here in southern Tasmania to doctors, GPs, working in those zones. As we said earlier on, this is Hamish, who's come over from Melbourne as acting manager for policy and advocacy at ASEM, and together we're representing ASEM. We do want to acknowledge the traditional custodians of the lands upon which the Tasmanian emergency departments are located. We greatly appreciate the opportunity to speak to you today and express our gratitude to the secretary of the Health department and their deputies for maintaining an open dialogue with ASEM.

CHAIR - Yes, thanks. Hamish, did you want to start with any comments?

Mr BOURNE - I'll probably defer to Juan.

CHAIR - Juan, so you're working now as an emergency physician?

Dr ASCENCIO-LANE - Correct.

CHAIR - Could you tell us a bit about your role and what going to work on a daily basis is like for you?

Dr ASCENCIO-LANE - I have multiple roles, part of it is being the emergency physician. A big part of my role is as a faculty chair, so I do represent all the emergency physicians across Tasmania within ASEM. As an emergency physician I work at the Royal Hobart Hospital, but have previously also worked in Burnie emergency departments, up in the north-west at Mersey and have had the opportunity to visit numerous times up to Launceston.

I have had a great exposure to the situation across all the emergency departments facing the Tasmanian population, as well as the healthcare personnel working within these departments. I must say that for me it is a massive privilege to be working in the emergency departments here in Tasmania, having come across from Ireland and having worked in New Zealand previously. I have always enjoyed working here and I have amazing colleagues, not just in Hobart but across Tasmania. We look out for each other; we are a small family that works well together to support each other whenever there is any major incident or where there is celebration.

But, over my time working here as an emergency physician, a staff specialist as well as a registrar, I have seen the deterioration that has happened within all the emergency departments in Tasmania. I have seen the deterioration of the health system as a whole in Tasmania. For us, as people who want to be there to help the Tasmanian population, it is heartbreaking to see. The fact that we are being asked to do more with less, the fact that we are having to trade patients in areas that are not set up to the standard that we want to can be heartbreaking. I have seen doctors who would have been amazing physicians in the ED leave because of the stress that is being put onto them. I have seen amazing nurses leave because it has destroyed them emotionally. I have seen the allied health personnel, the orderlies, anybody associated with the emergency department looking for alternative duties, because they cannot continue to work in the situation.

This is not just about ED; this is about the whole health system. Within the emergency department, we are extremely privileged to be working not only with the specialists within the hospital, but we get to have great connections with our GP colleagues and the community, as we are often the first port of call for their patients coming through. We train a lot of GPs coming through as well, and we see the stressors that are going on with them out in the community. We see the stress that's involved being a physician or a surgeon in our system, because it is failing everywhere.

We have an amazing relationship with Jordan Emery, the Chief Executive at Ambulance Tasmania, and with ACEM we have had an amazing relationship with Ambulance Tasmania trying to work forward. But we have seen the stress that happens with Jordan's team, with his paramedics who want to do the best for their patients - for all patients - and they are not being given the tools or the opportunity to do that. Again, just like the staff within the Emergency Department, there are some that are either leaving that profession, or reducing their time to try and keep their head above the water.

CHAIR - Quite a lot to unpack there, thank you for that overview. From what I am understanding, also from the data and from what other people have said and from what you have mentioned, the situation has changed quite quickly, particularly in your career. It is not simple, but can you point to what you think some of the key drivers of that rapid change have been?

Dr ASCENCIO-LANE - We all know that this is not just a single point or a single entity that has caused this situation to happen. Certainly, when I first started working here, we would see that there would be minimal ramping, if at all - patients were not waiting in the emergency department - to the point now that, particularly Launceston and the Royal Hobart Hospital, have some of the worst figures for access block within Australia and New Zealand.

The number of presentations has rapidly increased. We have seen over a period time the number of patients needing admission increasing by 63 per cent, whereas the number of beds has only increased by about 30 per cent during that same period of time. Our patients have gotten older, they have gotten more complex, or the population has increased, but unfortunately across the health system we have not moved with that number.

We have seen some amazing initiatives being put out by this Government and previous governments, and especially by Kath Morgan-Wicks and her team, with regards to secondary triage, that have really helped to alleviate some of the pressures for Ambulance Tasmania. We have seen Hospital in the Home - an amazing initiative - come through. We have seen all the different work go on within the emergency departments; but it is just not enough. We've seen the urgent care centres come through, which again have a role, but have nothing to do with access block. The urgent care centres are there primarily to deal with those low acuity patients that do not need admission. Those patients going to the urgent care centre do not contribute to access block.

That's where the focus needs to be on, it's access block in the whole of health care system issue that's happening. This is not just a GP problem. This is not just an emergency department problem. This is not just a specialty within the hospital problem. This is a whole health care system that's contributing to the attrition of the care of the Tasmanian population, who deserve better. It's causing the attrition of the physicians, of the staff within these facilities, who again deserve better.

CHAIR - There are big forces at play in the Australian health system which are part of that. Would you say that there's been a failure of resources to match the patient care delivery that's gone up over the years, for a range of reasons?

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Dr ASCENCIO-LANE - Absolutely. We can see that within Tasmania. ACEM has set out standards that 90 per cent of patients who are going to be admitted should be leaving the emergency department at eight hours. Unfortunately, we're at the point where 90 per cent of admitted patients are still in the emergency department by 23 hours. That's a massive failing for our patients. It's a massive failing for Tasmanians.

We have the opportunity to have one of the best health systems not just in Australia, but in the world. There is no other system that has a hospital like the Royal Hobart Hospital with all the subspecialties under one roof. We have the ability to provide all of this care for Tasmanians. Because we haven't moved with the time, we haven't allocated those resources appropriately, we're failing the Tasmanian population. We're not creating enough beds for patients to come into. We're not creating enough resources for inpatient teams to provide that care. Then, when patients are trying to leave hospital, we don’t have enough of those resources to put them back into the community safely. We've seen too many times when patients are being pushed out of hospital to try and create beds and they're having to be almost turned around and straight back into the emergency department to wait to go back up onto the ward.

CHAIR - A narrative which is prevalent or is being pushed at the moment is that it is a failure of GPs to do the heavy lifting, a failure of the federal government to provide enough money for GPs, which is essentially the cause of the ramping problem that's happening. What's your view about that?

Dr ASCENCIO-LANE - My view overall is that having been here for quite a while, and being the faculty chair, is that there seems to be this continual thing of blaming others - whether it's past governments, this Government, this executive team, these specialists, that specialist. We need to move away from that. What we need to work towards is what the public demand and what they require, and what they deserve. Certainly, within the GPs, I'm absolutely not blaming them. They are doing the best they can with the resources that they have.

We know that the GP-type patients coming into the emergency department or going to the urgent care centres are not the ones causing access block. The GPs are doing an amazing job out in the community with the resources that they've got.

One of the strategies that we would look into to improve things is certainly to provide extra support and resources for those GPs to be able to manage and look after those patients out in the community and to be able to provide timely care for them. We know that GPs are under-resourced and underfunded. Their ability to see their patients all the time is just not there. But these are not contributing to the access block. Its patients needing admission to the hospital who are sick, who have gone beyond the care of a GP in the community, who need in-hospital patient treatment. They're the ones that are causing the access block. They're the ones that are not getting the beds in the hospital.

CHAIR - And they're the ones, from the testimony that the committee has heard, who are at an increased risk of adverse outcomes and mortality because they're not able to get the bed when they need it, inside the hospital. Can you provide us with some more information? Any experiences that you may have had?

Dr ASCENCIO-LANE - From the statistics alone, we know that if 10 per cent of patients waiting on admission have access block, any new patient coming in that needs admission will have an increased risk of death by 10 per cent over the next seven days. That's data that's out there. That's well known. Statistically they are more at risk.

Offhand, from my own experience, I have certainly seen that experience where we have patients in the waiting room who are unable to get into a bed that we want to treat. As stressful as it is for the patients, and as awful as it is for them out there, it's heartbreaking for us. We're not there to see harm come to these patients. All of us within the emergency department want the best for our patients. When we can't get them into the right space, it's not fair. It's not fair on them and it's not fair on the staff.

When the paramedics bring in their patients on the ramp and they are asking for a better location and they can't, it's heartbreaking to see that. We do end up providing the best care that we can in really stressful situations, but it's not the right care that those patients deserve.

CHAIR - Your submission provides a range of solutions for improving data, and you recommend that there be a new access measure that describes three patient streams and sets distinct targets for those streams, and that those three different streams will reflect the

complexity of patient needs and the different pathways that patients can make after they've attended emergency.

There hasn't been a lot of information available on the situation of ramping impacts and the ramping numbers and the length of stay and so on. Can you provide information to us about why it's useful to have that sort of information and to set the targets - the stuff that you've suggested?

Dr ASCENCIO-LANE - With regards to ramping, we know that they're not in the ideal clinical space. We want to be able to offload those patients and get the paramedics back out to the community as quickly as possible. Getting the right data to be able to look up where the falls are happening is key to being able to provide the solutions upstream. We know that if we solve access block, those patients are going to go into a bed in the emergency department as opposed to waiting on the ramp or going out into the waiting room.

We know that once we start looking at discharge plan early on for patients, we start looking straightaway at the way that these patients are going to start looking to get home, that it makes all the teams aware. That's certainly something that I know within the Royal has started happening. They're looking to do that around other places as well, but we need to be more mindful of how we are going to get these patients at home safely.

CHAIR - ACEM has hospital access targets. Have you provided them to the Department of Health as proposed to measures? What has their response been?

Dr ASCENCIO-LANE - We had the hospital access targets sent out quite a few years ago and we discussed them openly with Kath Morgan-Wicks and the minister for Health at that time. They have accepted those hospital access targets. Unfortunately, because of the degree of access block that Tasmania has, there is not much that can be done with these. We do collect the data and hospitals around Tasmania do keep those data.

What we have been able to see is that within the emergency departments, for the patients that do get discharged back home or go to a short-stay unit, we are near enough reaching those targets, or we are at those targets. The main pitfall that happens is for those patients that are needing admission to the hospital. The patients that require inpatient management up in the wards are not meeting any of those targets.

One of the big ones, as I said, was that 90 per cent of patients need to leave the emergency department within eight hours, and those patients who have been admitted to the wards are not meeting that.

Mr BOURNE - I wonder if it might be helpful to provide a little bit more context around hospital access targets and why ACEM advocates for them as well?

CHAIR - Yes, that would be helpful.

Mr BOURNE - Many years ago there was a national initiative - the National Emergency Access Targets, which had a four-hour time rule or KPI to get patients seen and admitted, or discharged, that initially did bring about some positive trends in the admission data as teams started to have a look at how they could stimulate patient flow through the hospital. We saw over time that that started to degrade as the continued pressure on hospital systems was

exacerbated, that the numbers were being gamed at times, and they were really too aspirational at the time.

ACEM decided to go back to the drawing board and have a look at hospital access targets, recognising that the patient journey is different, also acknowledging that by having emergency access targets it continues to frame the problem as an emergency department problem when really, it is a patient flow problem. By calling them hospital access targets it's looking at a whole-of-system response to surges in demand, and that's really why we've gone for hospital access targets.

That in of itself is not the panacea for governments to accept hospital access targets, but it is about setting and agreeing on a set of KPIs for which you can start to then have initiatives that cascade down below that can generate patient flow, because we know that there is no one solution for patient flow, that there will be things that vary from health service to health service.

CHAIR - So you proposed this to the department of Health, and they're -

Dr ASCENCIO-LANE - They certainly accept it.

CHAIR - But not implemented.

Dr ASCENCIO-LANE - It's hard to implement in a system that's broken, so they certainly used it to collate the data. This is what's amazing within the emergency departments within Tasmania, that for the patients that we have data control we are getting towards those targets that are required for the discharge patients, or those patients that we admit to our short-stay unit. What it did highlight to the Government and to the hospital was that admitted patients were the issue.

CHAIR - Twenty thousand a year, on average, at the Royal Hobart Hospital.

Dr ASCENCIO-LANE - Yes, but they could not get into a bed up in the ward within eight hours.

CHAIR - Yes, so it makes it very clear which cohort of patients who are going to the ED are the ones where the issue lies.

Dr ASCENCIO-LANE - Yes, and again, that just highlights when people talk about urgent care centres helping to alleviate the EDs, it's not. We know we can discharge those patients within a reasonable time frame.

CHAIR - The national standard time.

Dr ASCENCIO-LANE - Absolutely. It's those patients who are being admitted that we fail.

CHAIR - Good. Thank you for clarifying.

Ms DOW - Thank you for presenting to us today. My question relates to the recommendation that you've made around dedicated discharge planners. I would like you to expand on that for the committee, and where you see those roles being critical across the

hospital system. It would be good for us to understand why there aren't those dedicated roles there. It makes sense for those to be in place now given the need to discharge people back out into the community, so anything further you can offer the committee on that would be great. Thank you.

Dr ASCENCIO-LANE - I think where I can talk from is really around the emergency department. Within our short-stay unit, as soon as we admit a patient in, we're planning about how to safely get them home. We have a team that works with us that we've got, particularly for the elderly patients, of how to get them out safely. We've got a team of nurses who are coordinating with their families, or if they are going to a nursing home or short stay, or if they're going home, how they follow them at home safely. We've got a team of allied health workers such as physiotherapists, occupational therapists and social workers as well that we bring in or they will self-activate to get these people out safely. That's from the time we stipulate they need to be admitted.

Certainly, within some of the teams - I can't speak about the hospitals up in the north and north-west, but certainly within the Royal there is a discharge planner that's meant to be available for these patients once they do get admitted. . Again, this is where the whole of hospital, the whole health system fails in that it's often a Monday-to-Friday system across the place, an 8am-5pm situation.

We hear of teams unable to get access to physiotherapists or social workers in a timely manner, and then those allied healthcare workers who either are being squeezed and pushed harder to try to get timely care to these patients - so again, it's expanding out and that's where it's not just about looking at the emergency department. It's about looking at where else we can look to make those gains, where else can we help provide that support for the patients, and we certainly see the benefit within the emergency department, within our own short-stay unit.

Ms DOW - Thank you. You make reference to the need for the changes in the demographics of the workforce and the experience that's been lost, particularly with people retiring earlier due to COVID-19. You make reference to the need for upskilling. Could you provide us with some more information about that? That was mentioned by a number of other people who presented to our committee. I would like to understand a bit more about how that is currently not working well, and if there was the opportunity for staff to be upskilled on the wards, for example, to be able to take more complex patients or the like, how that would work and what your further thoughts are on that?

Dr ASCENCIO-LANE - Yes. Certainly, within the emergency departments we have lost a lot of corporate knowledge, a lot of experienced practitioners, a lot of the healthcare workers who work within the emergency departments. That is due to those stressors of working in a situation where we're not providing the care that patients deserve. We've had to bring in a lot of junior staff to make the shortfall. The Royal Hobart Hospital last year had to cover a lot of the doctor positions with locums. We were lucky at times that we had some amazing locums but, again, it's an unknown quantity. They come in for a brief period of time; they don't fully understand the situation and it's not ideal.

We have an excellent emergency department and we should not be relying on locums. They don't really partake within the hospital education. They're not part of the mainstay of the hospital, so it's really hard to get them to buy into what the needs are for the Tasmanian population and it's another bandaid for a broken system. It's hard for me to discuss what their

needs are within the wards given that I'm an emergency physician and represent emergency doctors, but, again, education, support and upskilling are always necessities for staff. We hear stories of patients deteriorating up in the wards, and either the staff are overwhelmed by the needs for their care, unable to provide the care that they want for those patients, or, again, the intensive care unit has been completely overwhelmed and the patient is unable to get into those right areas.

This all comes down to the healthcare system isn't providing the numbers of beds or the numbers of care points for the population. We're continuously working at a high level of occupancy across all our hospitals here, but we should be aiming for a 90 per cent occupancy rate to allow that surge, to allow for those patients who suddenly deteriorate to go to the right place and not be managed in a place with excellent staff, but staff who do not have the right tools or equipment or support in those areas.

CHAIR - Thank you. On hospital capacity and beds, which you've talked about in your submission, you've made it very clear that over the 10 years of data that we've got ending in 2022 there has been a 68 per cent increase in patients who need to have hospital admission but only a 33 per cent increase in the beds available to receive them. Obviously, those numbers don't work, which is why we're seeing the current situation, in part. You've recommended building the capacity of hospitals, especially as we've got an even older and more unwell population coming down the line. I'm not sure if you're aware of where hospital planning processes are up to from your role. Is it a conversation? Where do you think the planning in the department of Health is up to? Are you engaged as an emergency physician in that process? Do you have an opportunity to have input?

Dr ASCENCIO-LANE - From ACEM we are always happy to be engaged and are always looking to be involved in these conversations. I'm not sure exactly where things stand. I know that a few years ago the strategic priorities were released and we were invited to help review those as well.

Hospital in the Home has been a huge step forward. I fully understand they're reducing the number of presentations to ED, they're helping to keep patients in the nursing homes, or helping to take the patients out of the hospital. But again, when we look at it, there are those patients who need care within the hospital, and that's filtering back down to the emergency department, back down to the care that the paramedics are or are not able to give.

From my perspective, I don't believe we have the right numbers for bed occupancy within the hospitals here in Tasmania. Again, I'm not privileged in the planning or the forward planning of that.

CHAIR - Hamish, have you had any part of those conversations since that strategic priorities plan came out?

Mr BOURNE - No, we haven't.

CHAIR - Okay. You talk about additional alternatives, like increasing hospital bed capacity, Hospital in the Home. Also, some other people have made suggestions about having better care provision in aged-care homes, especially so people can be discharged more quickly. Increasingly, older people are coming through, and they need care so they can be discharged

once they're stable. Do you feel that we haven't started down that path, but that's an important priority - to investigate those alternatives in addition to hospital bed planning?

Dr ASCENCIO-LANE - Yes, and that is what we always talk about with these. It's never just one solution. Often, what we keep finding in the past that there's often these bandaids put over to try to fix this broken system.

Moving forward, it has to be a multidisciplinary approach. We have to look for a whole range of solutions and brave decisions have to be made. We need to be strong about how we go forward.

This is where I go back to not setting up blame. We need to work collectively together for what the Tasmanian population needs and what they deserve. One of those areas is the elderly. We know that the Tasmanian population is increasing and it's an ever-increasing aged population as well.

They're a complex group as well, with multiple co-morbidities that do need differences of care. One of the groups to look at providing support would be GPs. Hospital in the Home has been looking at doing some of that work. I know there's a team within the Royal Hobart Hospital that is looking at that elderly population and how to get back out to the nursing homes. There are patients who just aren't ready to go back out there who do need that inpatient care, who have multiple complexities.

We've seen it time and time again, where some of these elderly patients are discharged too early because of the needs of the hospital, because we are overflowing, and they end up just coming back to us quickly and being stuck in the emergency department again for over 22 hours.

CHAIR - Thank you. Talking about the access block issue and the fact that it should be a problem that's shared across the whole hospital, not just a problem for the emergency department itself, you've recommended that routine delays of ambulance offloading over 30 minutes should trigger a systematic review of the hospital and the emergency department and anything over 60 minutes should have an escalation policy and an incident review.

We've heard from the Launceston General Hospital that is almost all day, every day. How do you intervene in a system where it's broken and where it is at red all the time? What does accountability for addressing access block being shared across hospital departments look like to you?

Dr ASCENCIO-LANE - We all work in these departments, not just Launceston, but across the state, where there's continuous escalations. I've seen it where we use to go to a level 4 escalation because of the degree of access block, and people have almost become numb to it, that it's just part of everyday work and it doesn't mean anything.

Again, like in Launceston, unfortunately, because the whole healthcare system is broken, that it filters back. It's like the canary in the coalmine, that ramping, that degree of access block is showcasing what's gone wrong with the whole system. Unfortunately, what happens is that people just become immune to it, it is just an everyday occurrence. There doesn't seem to be a solution.

Doing these short-term fixes isn't working anymore. Continuously we've gone through doing these little bandaids, but we actually haven't been addressing the whole system issue. We are getting better at it, and certainly working with our colleagues throughout the hospital, with the executive and with Kathrine Morgan-Wicks. There is a complete understanding that this is a whole-of-hospital system issue that people are beginning to take ownership of their patients. This is our patient. That patient going through the emergency department deserves better.

It is the same with the hospital access targets. We want to get to 90 per cent of all patients leaving all emergency departments within eight hours to go to the ward, but, because the healthcare system is broken, we are not. Over 90 per cent of those patients are staying for more than 22 hours in our emergency departments. We know that filters back to the ramping. Our hearts are breaking for our paramedic colleagues who are unable to leave those patients and then there are deteriorations happening out in the community. It is all a symptom of that access block, of the whole healthcare system. I don't want to say to the paramedics, 'You can't leave and go off and help that patient'. We all know the stories in the community of those patients who are suffering.

CHAIR - Who may be at the highest risk or suffering the most laying for hours with broken bones and unattended to.

So, what we have heard, like your view, that possibly we don't measure the risk to the patient on average. We don't do that. Physicians, nurses and paramedics are treating the person in front of them. With the triage system, which triages people into emergency, that triage doesn't take account of the person who is not being answered in the community at the end of a 000 call, and doesn't take account properly of the person who is on the ramp who in that situation would be at higher risk than someone who's in the emergency department. And, someone in the emergency department on average, who is not yet stabilised, would be at higher risk than somebody who is on a ward, on average.

I suppose what you are saying is, it needs to share across all the departments, and that would mean pushing people further into the hospital as well as obviously looking at all the ins and outs. Can you talk about the step of moving people into wards, because we've heard people who recommend that that should happen more frequently even if it means people are on beds in corridors? That obviously would create pressures in that ward, but a view is that it would be less than the pressure and less than the risk that's currently occurring in emergency departments.

What is ACEM's view about the situation?

Dr ASCENCIO-LANE - It is always a tricky one because we are not here to put extra pressure on the staff up in the wards. There are times when we have that surge within the emergency department. Unfortunately, we have no control of what comes in. We often talk about the unknown out there, that we don't know what that patient is like in the waiting room or what the patient is like in the community.

When we have certain patients who have been with us in the emergency department two hours, stable, who have been cared for, who have been completely worked up, when we know that there may be a bed becoming available up in the ward, then certainly allowing that

safe patient to go to the ward and letting that unknown quantity come into the emergency department is a far better thing for the community as a whole.

Certainly, it needs to be done correctly though, because we have seen the fallout where nurses on the ward get pushed too hard and they get stressed in the same way that we're -

CHAIR - No-one wants to add stress to other people and risk to patients.

Dr ASCENCIO-LANE - Absolutely not, and that comes back to that whole healthcare system failing. Again, they're not being given the right numbers of beds; they're not being given the right support up there. They're given increasingly complex patients and we don't want to break them, either. There are extremely valuable staff up in the wards, highly skilled staff. When they get their right patient, they're the best people to look after. That's what we're looking for, is to get that right patient to the right place at the right time. That's what we want for the patients in the community. We need them in the emergency department if that is what they need; they need to be with us and we are the best people for them and we want them in as quickly as possible.

Trying to put the squeeze on either side just isn't working. We need to be careful how we look at ramping and we need to make sure that we're doing it in the right and safe way for these patients, that we get them into a place where they can be cared for by the right nursing staff, by the right physicians, by the right allied healthcare workers. We are always at risk of robbing one area to try to feed the other and again that is just creating that bandaid. If we get access block fixed, if we don't have that problem of patients being able to get into beds and we don't have ramping, we don't have the ambulance officers waiting, we don't have that delay going out to the community.

CHAIR - Michelle, I don't see your hand up but we're getting to the end of time. Do any other members have questions they want to ask? Anita? No?

Ms DOW - I'm good, thank you.

CHAIR - Well, on that then. Would ACEM's view be that it's really, as well as increasing bed capacity and planning for increasing bed capacity and doing work in the preventative health space in the community, that the real focus from a hospital management needs to be on the discharge and supporting the discharge side of things?

Dr ASCENCIO-LANE - Yes. Absolutely, and that's one of our key points. Again, we never just look at one point. It is a complex situation but, like I said, it needs big, difficult decisions to be made. Rather than continuously going around in circles and doing the same thing day in, day out, that we've been doing whether it's rebranding one thing to another, we need a whole-of-system change. We need to be there for our patients.

CHAIR - You talk about unsuitable interventions, unintended consequences, in your submission, one of which is a rapid offload protocol where you say ACEM doesn't support policies that allow ambulances to leave a patient in a transition area where there's no capacity with the ED to care for that patient, and other jurisdictions have tried a model of leaving patients at the door of the ED without any transfer. What are you suggesting there, because I think there is a proposal to move so that ambulance staff are back on the road within a period of time? What would the response to that be to keep patients safe in the emergency department?

Dr ASCENCIO-LANE - I think we need to be extremely careful how we do this. I think, again, even though those ramped patients are within a healthcare facility, if they're not cared for by the appropriate person, they are at risk of coming to harm. We know that if they're being ramped, they're unstable patients who do need timely care and intervention. If we're placing these patients into a zone within the emergency department where they are not being monitored, where they do not have staff available to look after them, they will come to harm and that is not what we want.

We are really lucky that we work really well with our paramedic colleagues and with Jordan Emery and his team and they don't want to be doing that, either. They don't want to offload their patients knowing that nobody is going to be caring for them. We've seen it too many times when either they're looking after the patients on the ramp, and I think if they knew that they offloaded a patient within the ED with nobody looking and they deteriorate, they would be devastated. So, we need to get this right. We need to make sure that these patients who are coming in have somebody looking after them. They have to be in a safe place. They have to be in the right place. We cannot just offload to where they are not being cared for and that puts them at a huge risk.

CHAIR - The onus is on the department to have the discharge supports, for people to be able to move into the community in an appropriate and safe way?

Dr ASCENCIO-LANE - Again, it comes back to the whole of the hospital that we have the ability for patients who are on the ward who are ready for discharge and vacating the beds, that those beds become available - so that we can get our patients out of the emergency department upstairs to vacate the beds so those patients that are coming in by ambulance go into the appropriate bed with the appropriate care.

CHAIR - Thank you. We could talk about this for a long time; are there any other points that you wanted to make while you are here? We have to wrap up shortly.

Dr ASCENCIO-LANE - No.

CHAIR - We should finish with the comment that you made in your submission which is that the traditional ambulance respond, stabilise and transport focus of the ambulance services, raises what is causing the ethical dilemma for paramedics who are effectively put in a situation of having to continue to provide emergency medical care for a patient beyond their scope of practice.

That's the basis for the start of this inquiry, but what we've heard and what you're telling us today is that it is the whole system which is creating this crunch, and the level of resourcing and the leadership is what's required to come up with a different approach that is not just more of the same. Trying to focus on solutions that only deal with part of the system in the absence of looking at the whole system would, in your view, be moving the problem from one place to somewhere else, possibly with just as bad consequences in the other place.

Dr ASCENCIO-LANE - Correct.

CHAIR - Thank you so much for presenting to us today. We appreciate it. Thank you, Hamish, for coming down and being here. I acknowledge the work of ACEM and the role that

you play in Tasmania providing this voice for emergency medicine, and the experience that you have across Australia and New Zealand. It has been a really powerful and important voice, so thank you for your advocacy.

I just want to remind you before you leave, Juan, and Hamish - you are going back to Melbourne - but if you say anything that might be defamatory or result in court action potentially outside of here, you are not covered by parliamentary privilege anymore. Thank you very much for coming.

The committee suspended at 2.53 p.m.

The Committee resumed at 4.00 p.m.

CHAIR - Welcome, Toby Rowallan, and thank you very much for coming. Before we start today, I want to ask you have you got the information that the secretary of the committee sent to you beforehand?

Mr ROWALLAN - Yes.

CHAIR - In that, it talks about the fact this is a committee of parliament and for us to do our work and get the best possible report, we need to have people able to speak freely and frankly about any matter that would be useful for us. And so, in today's committee, you are covered by parliamentary privilege which means that you can speak with the freedom of not being sued or having any other court action taken against you. That privilege doesn't follow you when you leave outside, so if you refer to matters in the committee today that could be defamatory, you won't be covered by parliamentary privilege in that instance. Do you understand?

Mr ROWALLAN - Yes, I do. Thank you.

Mr TOBY ROWALLAN, AMBULANCE DISPATCHER, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Thank you very much for appearing. Would you like to start by just telling us what your current position is? Also, I thank you for the submission that you've given us. It's really comprehensive. We've read it and so we'll just talk about the things that you've raised here and any other matters you've got today. If you just talk about your position, and do you want to make any opening comments or statements?

Mr ROWALLAN - I do have a statement I want to make. My position is an emergency medical dispatcher for Ambulance Tasmania. I've been doing that job for 28 years, so hopefully, I know what I'm doing by now. I've spent about 10 years acting as team leader in the same area, which is looking after the dispatchers and call takers in the communication centre.

I want to start by referencing an article from *The Conversation* published on 13 November 2021. The title of the article is 'Nurses Don't Want to be Hailed as Heroes During a Pandemic - They Want More Resources and Support'. This is an excerpt from that article:

> Nurses demonstrated that they will do almost anything for their patients, even risking their own lives. As of the end of December 2020, more than 1.6 million health care workers worldwide had been infected by COVID-19, and nurses make up the largest affected group in many countries.
>
> For this, nurses have been hailed as heroes. But this can be a dangerous label with negative consequences. With this hero narrative, expectations of what nurses should do become unrealistic, such as working with inadequate resources, staffing and safety precautions. Consequently, it becomes normalized for nurses to work longer hours or extra shifts without consideration for how this may affect them personally.

So, that is just that excerpt. It doesn't take long to find a mention of nurses as heroes by the media and it's so frequent it's almost pervasive. Politicians are just as guilty. Paramedics and doctors are often labelled as heroes as well.

If you haven't worked out what the problem is - hopefully you will have - I'm going to spell it out anyway. What does a hero do? If you consider when someone saves a child that is not their own from drowning, they will rightly be called a hero. They will receive accolades, attention and gratitude. What won't happen? They won't get paid. That is the point. Nurses, paramedics, doctors, emergency medical dispatchers, are not heroes. They have chosen to do the job. They apply their commitment, determination, perseverance, fortitude and resilience to do those jobs. These qualities are essential if you want to survive in the job for any significant length of time.

Performing a heroic rescue like saving someone from drowning is intense and difficult, but for the hero, it's just a moment. It happens quickly and then it's over. This does not apply to paramedics, nurses, doctors and ambulance dispatchers. The intense and the difficult is a daily event, a constant stream of pressure and effort and these days with almost no let-up.

On Monday night I was the dispatcher for the southern region and in the communications centre we had no team leader after 9 p.m. and even that was because the day shift team leader stayed back for three hours. We had no deployment supervisor from 8 p.m. until 6.20 a.m., the aeromedical nurse coordinator finished two and a half hours late in order to manage an urgent medical transfer by helicopter and also to assist with any clinical requests, given that there was a lack of supervisor.

During that shift, and this is Monday night just gone, numerous priority 1 or emergency cases, waited until there was a response. At the very start of my shift, within minutes, there were four emergency cases waiting and no one available to respond. Why not? Because the day shift crews were ramped at the hospital or on other cases. Fortunately, the night shift crews commenced at 7 p.m. As they signed on, they were dispatched to those cases, so the delay was not as bad as it might have been, about 15 or 20 minutes for each. Another case that had waited already for far too long, which had been a lower priority, was upgraded to a priority 1 and a crew dispatched.

To be fair, as the night went on, the ramping at the hospital was not as bad as it may have been on other shifts, but the emergency cases just kept coming in. It was very difficult to get the crews breaks. On this shift on Monday night there was no paramedic at Dodges Ferry, only one volunteer. There was no paramedic at Kingston; there was no paramedic crew at Bridgewater. After midnight there was only one officer at Glenorchy and none after 4.30 a.m. There were no intensive care paramedics on duty after midnight except for the officer rostered to the helicopter. As I mentioned, the helicopter was busy for most of the night and that officer was not available to respond to Hobart until about 3 a.m. Fortunately, they were not needed.

The Sorell crew got one break during the entire shift. They spent just 20 minutes at their station. That was less than 10 minutes at the start of their shift, checking their vehicle and equipment, and about 10 minutes or so at the end of the shift signing out their drugs and cleaning their equipment. They were on cases or at the hospital for the rest of the night. I think they spent about three hours on the ramp, perhaps a little less. They had one break in Hobart, which was after midnight, so they worked about six hours before a break. The other crews were much the same, although the call volume did finally ease about mid-morning and most of

the crews did finish on time, but not all. Some managed about an hour back on station at the end. Until that time we had a regular procession of priority 1 cases that waited for an ambulance to come clear of the hospital. The delays were not as bad as other shifts that I have experienced, but there was a significant number of cases that did wait before I had someone to send.

This is not a once-in-a-month occurrence. This is a near daily occurrence. Five days out of seven, or something like that, will be the average. I do not have the exact statistics. That is something you would have to ask the various representatives of the department. On Monday night we also had a single paramedic who had offered to be on-call. They were called out twice. If they had not been available, those cases would have waited about 15 minutes longer than they did.

This is how you break people. This intensity, this pressure, is immensely fatiguing. I know it is not my fault that there are not enough ambulance crews and there are not enough beds in the hospital, but for me when I have an emergency case waiting - a situation that could mean someone's life is at stake - then you can't tell me that is not my responsibility, because it is. It is my job to get someone to that person and hopefully the paramedics could start to reverse the situation. If I can't do that job because we are understaffed and the hospital is understaffed - now you can imagine how that is for everyone across the health system. All the dispatchers, the paramedics who know that there are cases waiting, but they have not had a break for several hours, the nurses and the doctors in the hospitals, who likewise I am sure, don't want to ramp the ambulance crews, but they have little choice if they are going to ramp their own situation.

Most of the delays on Monday night did occur because of the ramping, even though the ramping was not even as bad as it has been. The combination of being short-staffed and some of the ramping caused those delays. I would like to apologise to everyone who had to wait for too long for an ambulance, but I did my best. I can only do so much with what I have got. Maybe, however, it is not me that really needs to apologise.

Time and again we are told by the hospital via the supervisors that there are no beds, there are no beds, there are no beds, the emergency department is full, the waiting room is full, and there are no beds in the hospital. Or sometimes there might be four beds in the hospital, but because the Emergency Department is full you know they will be taken before too long. Even though you could fluff around at the edges with things like patient flow, in-hospital communication, out-of-hospital care and support services, after-hours doctors services; all these will, I have no doubt, make a small difference in assisting what's happening, but they are smaller and they will not ultimately fix the problem with the hospital. That is, the number of beds. That is also covered in my submission. They won't change the reality that the hospital doesn't have enough beds for the current, let alone the future, expected demand.

CHAIR - Thanks, Toby. I find that really hard to listen to. I read your submission and you talked about an instance in 2022 which was a truly horrifying night. And yet, you've just outlined this week almost the same sort of experience. It seems that over that past year and a half you've been experiencing on a regular, if not daily, basis this huge level of burden, and the trauma, as you say, of not being able to do your job. I acknowledge that and recognise that we understand the gravity of the situation and that everyone is under a terrible amount of pressure.

Can we talk about your comments about extra paramedics and dispatchers? There clearly is a problem when people aren't turning up for shifts and shifts aren't being filled. There is the question about what happens when people are on shifts, but people aren't turning up to be dispatchers. Have you lost people? How many people are working in the dispatch centre? How many are meant to be there for the whole state?

Mr ROWALLAN - It varies in terms of what time of the day. The shifts that we have vary between 12¼-hour shifts and nine-hour shifts and eight-hour shifts, depending on the time of day. As I say, how many are supposed to be there? I didn't get a break after midnight because of our shortage on Monday night. Normally, the team leader would cover the breaks after midnight but we didn't have one. The supervisor also assists with liaising with the regional supervisors in terms of what's happening with the waiting cases. We did have a supervisor for the region itself, looking after what's going on at the hospital and so forth. Obviously, they were very helpful in trying to do the best with what we had.

This is the thing: everyone is always doing the best they can with what they have. In terms of the shifts and the shortages, it is actually worse on the road. There are more paramedics calling in sick for their second night shift. Also, those who are working afternoon shift and one night will often work the afternoon shift and then call in sick for the night, which leaves everybody short. If we'd been fully staffed, it might have been that we may not have had any delayed priority 1 cases, even with the ramping that we had. That is how much of a difference that makes. If we'd had an extra crew as well as the other stations that should have been staffed, there wouldn't have been any cases that waited too long.

CHAIR - They would have ended up in hospital with extra people ramped in that period.

Mr ROWALLAN - There might have been slightly more ramping as a result, but we wouldn't have had the delays that we had.

In terms of how many people we have who are on long-term sick leave, how many people are calling in sick, that is a statistic that I don't know. The ambulance chiefs and the Health department can answer those questions. It's a very regular occurrence and it is because of the intensity of the shifts that we are working.

CHAIR - What we have now is that people with very high need and at high risk, in P1s, are remaining unresponded to in the required time. So they might be at risk on the ramp but they are alone without any support until an ambulance reaches them. They are at obviously increased risk where there is nobody there to do anything for them, so they are essentially the highest risk in the whole system and the most at risk of an adverse event because there is nobody who is there. And so, having those extra paramedics on shift so that people can at least be attended to, even if they are on the ramp. It would be a lower level of risk overall in the community.

Mr ROWALLAN - Absolutely. I can't remember the longest waiting case we had on Monday night before someone was allocated to it. It might have been 20 or 25 minutes. They're supposed to be allocated immediately.

CHAIR - How frequent are the priority 1 calls that are waiting for resources?

Mr ROWALLAN - I can't remember the amount that delayed on Monday night, but it would have been seven or eight at least.

CHAIR - Every minute of delay matters for a P1.

Mr ROWALLAN - We are supposed to dispatch them immediately. If we have an available crew, the closest available crew is supposed to be sent. That's the policy. If you don't have someone, that is a problem because the potential is there. As in my submission, we did have a case on that shift that I described where it waited 45 minutes before someone was dispatched and the outcome was even worse when the crew arrived. I don't know what the outcome was for that person, but that highlights the risk. That's the worst possible outcome.

CHAIR - You said there were seven to eight on Monday night, but that's not the worst night. What was the worst night in your recent memory?

Mr ROWALLAN - Probably the one in my submission, but I have had similar shifts to Monday night in the past six to eight months, where there were similar level of delays and worse shortages of staff in the region. There have been times when there have been five crews uncovered.

CHAIR - Across Tasmania?

Mr ROWALLAN - Across Hobart.

CHAIR - Across the southern region?

Mr ROWALLAN - Yes, just in Hobart. The shortages have been a little less in the rest of the state, but there have been some, but Hobart is much more intense usually than the north and the northwest of the state.

CHAIR - In terms of trying to get crew?

Mr ROWALLAN - In terms of caseload.

CHAIR - In your submission you said what it was like when you left that shift in 2022 and where you had an appalling number of high acuity cases that were not answered. You said:

> This was the worst shift I'd ever experienced. Never before had I seen so many cases wait, so many high-priority cases at that. At the end of the shift I was physically and mentally exhausted. I was anxious, irritable, morose and despondent. I drove home somehow. I probably should not have driven. I did not want to return to work. Despite the exhaustion, I had trouble getting to sleep. I can't remember if I had to return to work the next night.

That's obviously had a huge emotional toll on you. What support have you had from Ambulance Tasmania for working in situations like that?

Mr ROWALLAN - To be fair we do have a reasonable amount of mental health support for staff, and that has increased significantly over the last couple of years. Partly due an adverse event a few years ago, there has a significant increase in mental health support, some of which

I've been part of helping to progress as well, including a peer support program of which I've been one of them, but also with additional mental health services provided, psychologists, et cetera, who are available. That has definitely happened. With my experience and knowledge I'm better at seeking additional support than perhaps someone who's a little younger and less experienced and necessarily someone who's a little more close-minded about getting help when they need it.

This isn't really about me. This is more of a whole-of-ambulance problem, because it's all of us who are facing similar situations. I don't know how the crews felt yesterday morning after Monday night. I don't know how many of them had to return for another night. I suspect that any of them who were supposed to return would not have. If I had had to work last night, Tuesday night, as a second night, I would have called in sick. I would not have been able to do it after Monday night. That's what happens. It's just so intense. It's so fatiguing when you're working without a break and you're under-resourced.

CHAIR - Not wanting to minimise the reality of the need for more resources and to do things differently, but, in addition to that, do you think that there is a case for mandating regular professional support for all staff? Rather than leaving it to people who may always go to the bottom of the list and requiring it to be not in a shift time but in a separate time?

Mr ROWALLAN - That's an aside. I think maybe that would help. I think that's a discussion that maybe the directors of Ambulance Tasmania need to have and talk further about as they increase the support that's available. But it reminds me of what I put in my submission as well: every company that says, 'How can we improve mental health in the workplace?', and every employee says, 'How about giving us more resources, more staffing?', and they go, 'Not that, how about some yoga and we'll buy you a pizza once a month.' Something like that. Not to say that that's the attitude of Ambulance Tasmania, because I don't think it is. But, really, the thing that addresses these issues is staffing and more resources, not psychological support.

CHAIR - Yes, point taken. Don't worry, we're hearing this. Point taken.

Mr ROWALLAN - I think you're not wrong, and that we need to do as much as we possibly can to support staff in dealing with these difficult situations because it's not likely to get easier any time soon.

CHAIR - We've heard from paramedics that they've been exposed to continual calls while they're on a ramp. They're hearing P1 cases, sometimes even P0 cases. These are ambulance sirens, all bells and whistles as fast as possible situations. They're hearing them going unanswered.

Mr ROWALLAN - Yes. One of our policies is we do, what's known as a general call, where we radio out that there is a priority 1 or a priority 0 case and we then add that someone is responding from wherever it might be. The reason we do that is so that a crew who has not yet told us that they're going to be available somewhere might actually hear that and say, 'Oh wait, we're actually closer to that' than the crew that is responding. But the policy is also that if we don't have someone to respond, we still make the general call and we will say - and I had to do this several times on Monday night, of course - 'Priority 1 case at Moonah, or wherever, no available response'. That lets those crews that might be about to be available to sing out and say, 'Yes we can go', which actually did happen on one of these occasions on Monday night. But the downside is, as you say, if they have their portable radios on, no matter where they are,

they will hear that general call and they will know that there's no-one available, and so they're all feeling that pressure.

CHAIR - The whole system feels it.

Mr ROWALLAN - Yes.

CHAIR - Michelle, do you have any questions at this point?

Ms O'BYRNE - I think the submission was incredibly detailed and I've got a lot from it already. I really do appreciate you coming to talk to us. I don't think I can ask anything that would add more than what you've told us.

Mr ROWALLAN - Thank you.

CHAIR - So, Toby, I'd like you to talk about the not-enough paramedics and the not-enough dispatches. How would we reach an informed view about what enough paramedics in the current circumstances would look like? It seems until a whole lot of initiatives are put in place, there will be ramping and shortages of staff. How would that information be gathered? There have been reports recommending increased numbers of paramedics.

Mr ROWALLAN - I don't know what the organisation is doing as a whole, but I know that if we were fully staffed on every shift, we would be having so many fewer delays - so many fewer emergency cases would be delayed. It would be much more ideal.

CHAIR - That would look like having more people employed to be on a shift and not necessarily needing to go and work?

Mr ROWALLAN - If we had been fully staffed on Monday night - this is not even extra rostered crew, just the crew that we are supposed to have, if we actually had all the crews we were supposed to have - we would not have had the delays we had. Same with the shift in 2022; if we had the rostered crew that night, the delays would have been halved at least. It was a particularly busy night. If we'd had the full rostered crew, we probably still would have had some delays, but it would have been about half the delays that we did have.

One of the issues is we have a lot of sick leave, as I said, a lot of people who are calling in sick for their shift. I absolutely can't blame them because of the intensity of what's happening. But if we had extra people who were rostered to fill those gaps as they came in, we would end up just simply being fully staffed. However, sometimes one of the issues becomes that if somebody knows there is an 'extra' rostered on, it actually encourages people to call in sick sometimes because they think there is an extra so they will be covered - so they might just take the shift off. Having said that, it's partly a factor of the intensity of our workload. If that wasn't the case, then people wouldn't be thinking like that. To start with, if we were fully staffed, then we would have some shifts that were actually quite pleasant and very well manageable, where they are very few delays.

We have priority 2 cases - which are one step below emergency cases, priority 1s and priority 0s - and they are supposed to be dispatched immediately. They are not supposed to wait, but some of them wait for hours and, as I said on Monday night, there was one of those cases that had already waited for two hours before I started my shift. It was then upgraded

because we decided that it had waited too long. It was becoming more of a risk because when there is no-one on scene, you can't be sure exactly what's going on until you get there. We do make call-backs and we follow a process. We try to minimise that risk, but when you are short staffed, either in the communications centre or on the roads or both, that just increases the pressure and increases the likelihood that you will make a mistake and something will slip through and that has happened.

CHAIR - What is it like for you to have to tell a paramedic who is on the ramp and finished their shift that they need to go back on the road and stay for longer.

Mr ROWALLAN - There's a whole bunch of rules about paramedic breaks and shift time. If someone has actually finished their shift and they are still on the ramp, they can't be dispatched to another case. They can, if they hear a general call and say 'yes, we are finished but we'll go to that', they can choose to. That is their decision to elect to go if they have finished. They don't need to go. That does sometimes happen, especially with the priority 0 cases, because a priority 0 case will be an acute life-threatening emergency, where someone is either not breathing or is gasping for breath, for example, or something like that where it is already a situation where a life is in imminent danger if not already so.

Those priority 0 cases, a crew will be interrupted for their break. If they have got to a point where they have not had a break after six hours, they can only be dispatched to priority 0 cases. Sometimes you can have bad luck and they can be sent to a priority 0 even at that time and I've even had a situation when a crew was sent to a priority 0 again, after they had just done a priority 0 case. So, they effectively had worked eight or nine hours, doing two priority 0 cases in a row at the end of it, which -

CHAIR - Because the paramedics were not available because they were on the ramp or they hadn't turned up to fill a shift.

Mr ROWALLAN - That crew just happened to be nearest to where the case was. We will interrupt a break if it is a priority 0 case, no matter when that break is happening, no matter where they are. They will be sent because it is a priority 0.

CHAIR - But they won't be sent if they're on the ramp?

Mr ROWALLAN - But if they are on the ramp, they won't be sent. Now, just to be clear, we do have an agreement with the Launceston General Hospital where we can page crews off the ramp. We have an agreement, which has been made, if we have a priority 1 or a priority 0 case and there is no available response, we can page that crew and they will hand over to the nurses and say, 'We have a priority 1 or 0 case that we need to respond to'. It must be that we have no-one within 20 minutes or so of being able to respond from another location or expected to be able to respond. If there is no response, then we can page off the ramp.

We do not have an agreement like that with the Royal Hobart Hospital nor with any of the other hospitals. Having said that, if I ring the Royal Hobart Hospital and say, 'I have a priority 0 case and the only crews available are there with you', I am quite sure that they will do what they can to assist in helping release a crew and sometimes we will find that the crews on the ramp will also do everything they can to consolidate the patients they have, sometimes even splitting crews so that someone responds. When it's a priority 0, we are doing absolutely everything to make sure that we get there, but the priority 1s are a little bit different.

CHAIR - Can you explain why there hasn't been a protocol developed with the other hospitals and only for the LGH on that issue?

Mr ROWALLAN - The negotiations have occurred. I am aware of that much.

CHAIR - Between Ambulance Tasmania and hospital CEOs?

Mr ROWALLAN - Yes, but -

CHAIR - How recent was the protocol developed with the LGH?

Mr ROWALLAN - Quite some time ago. It has been modified a little bit in the last year, but you would have to ask the ambulance chief executive and directors about those details.

CHAIR - Okay, but the CEOs of the other hospitals haven't reached an agreement with Ambulance Tasmania about that situation?

Mr ROWALLAN - No.

CHAIR - Okay. So, at the moment, there is in the south and the north-west -

Mr ROWALLAN - There is that limitation. Yes.

CHAIR - There are potentially P0 and P1 calls that don't get responded to immediately -

Mr ROWALLAN - Because we can't get them out of there. Yes.

CHAIR - Because we can't release people from the ramp.

Mr ROWALLAN - Priority 0s are a lot rarer, but -

CHAIR - Has that happened in your knowledge?

Mr ROWALLAN - Yes.

CHAIR - So there has been a P0 call, which is an imminent, life-threatening condition, and there have been -

Mr ROWALLAN - No one to go.

CHAIR - Paramedics on the ramp and there hasn't been a protocol with that hospital for an emergency department staff member to walk in and take over, or some other resolution to the situation?

Mr ROWALLAN - Yes.

CHAIR - So ambulances have been sitting there at the hospital -

Mr ROWALLAN - Stuck. Yes.

CHAIR - Empty when they haven't been - and a person has been having a life-threatening emergency?

Mr ROWALLAN - They're not empty because the crew still has a patient on their stretcher in the hospital. So, they can't get out.

CHAIR - And for years, there has been a conversation presumably that has been on the table because there has been a protocol developed at the LGH.

Mr ROWALLAN - Yes, so, my understanding is they have tried to negotiate something similar with the Royal Hobart Hospital and they have had a change to the protocol where we can request a tier 1 off-load, they call it. That is designed to enhance their ability to move patients through the system, however, it only occurs for a limited time and then it finishes. You would have to talk to hospital staff about how the tier 1 off-load works, but it is -

CHAIR - Anyway, it's not related to a particular instance where a P0 might get called.

Mr ROWALLAN - It's more specifically related to when we have the priority one cases waiting and unresourced and we will then go and ask them. We have - and I don't know if anyone else has talked about it in these hearings - escalation levels and they're related to our availability of ambulance resources in the suburban, urban areas of each region. Level 1 is everything is good and we have 80 per cent or more available resources. Level 2 is about 60 per cent of resources are committed, but we still have about 40 per cent of our own, though I cannot remember the exact number. Level 3 is where we have over 80 per cent of resources committed, or even 100 per cent, but there are no priority 1 or 0 cases waiting. Level 4 happens after we have priority 1 or priority 0 cases waiting with no resources available.

CHAIR - Thank you. You have also talked about the possibility of changing and restructuring the hours that people work and the shifts people work, and you talked about the issue for people working night shifts in particular, and that HACSU has been advocating for workers over 55 to be given priority removal from night shift work, but that because of a cost issue this has been ignored by the department of Health and Ambulance Tasmania. Can you talk about why that matters and whether other jurisdictions have a different structure of shift hours?

Mr ROWALLAN - I am not sure of other jurisdictions in terms of that. Originally, in the communication centre we used to do 10-by-14 shifts, so we would work a 10-hour day and then a 14-hour night. We changed several years ago to 12-hour days and 12-hour nights, but we also put in a nine-hour shift that is either a day or alternating to an afternoon shift; it starts at afternoon and finishes at midnight. That reduced the night shifts that we are working as emergency medical dispatchers by 25 per cent, which is an extraordinary thing and a big improvement - and as someone who is not getting any younger, definitely helped manage that fatigue.

The situation is that our bodies are not physically designed to be awake between midnight and 6 a.m. It is the worst time for someone to be awake, never mind making life-changing decisions for people, never mind driving in an emergency ambulance at high speeds, and also then having to give life-saving care to someone in the middle of the night. We are not supposed

to be awake, but of course someone has to, but we need to manage that better. We need to manage our shift times better.

In my view, 14-hour night shifts are not at all safe, because the crews can still finish late. Fourteen hours can end up being 16 hours, or even 17 hours. We might have a crew sitting, say, at Sorell, and they might be the nearest crew to go to somewhere like Dunalley, where there is no ambulance. They might be sent to that with 15 minutes left of their shift. They still have to get out to Dunalley. We are not going to call them off when they are 15 minutes away from Dunalley just because their shift is finished. That is not the way it works. They still have to go to that scene. They still have to assess that patient and treat that patient. It might be they get there and say, 'This person needs to go to hospital'. It might be that that person is quite sick and is not suitable for handover to a day shift crew, which we would otherwise offer if we can, because obviously we are trying all the time to minimise this situation.

Sometimes it does not work. They might have to go all the way to Hobart, and what if the hospital is so busy that even that category 2 patient - if they are a category 2 patient - is ramped, and they are stuck there, and they cannot handover because they have given schedule 8 drugs and that are not suitable for a handover?

CHAIR - This is not a hypothetical; you are talking about situations like this which -

Mr ROWALLAN - This sort of thing has happened, and it happens all the time. Not every crew finishes late, but it is often enough. We try really hard. As a dispatcher, a lot of our job is about managing and looking after the crews. Trying to get them breaks, trying to get them to finish on time, and trying to look after their safety. We have an extensive safety protocol about how we manage that and about the risks that they might be facing.

CHAIR - You have made some recommendations here that 30 hours of emergency care should be considered comparable to one week of full-time work.

Mr ROWALLAN - Yes, and especially when it's a shift after midnight. The notion of full-time for a shift worker means - for the team leaders, and they don't do the shorter days or the afternoons - they are doing 12-hour days and 12-hour nights. In their block, they're working 48 hours in a week, not 38.

CHAIR - Do you think that those sorts of changes would make a difference to workforce retention?

Mr ROWALLAN - It absolutely would.

CHAIR - And it would make a difference to the kind of emotional burden that people carry with the work that is being done?

Mr ROWALLAN - Yes. I'm currently working full time, and I'm considering reducing my hours. Not something that has just occurred to me now, I've been thinking about it for a while; reducing my hours by at least one shift per block. There are plenty of other ambulance staff, on-the-road paramedics and in the communication centre, who are working not half-time, but part-time hours. They are working 0.7 of a full-time roster.

CHAIR - You are saying more resourcing is needed to safely keep people working the number of hours that they are working. There will be more resources for more people to fill shifts and retain people's level of pay, but to drop the number of hours expected for that level of pay to enable people to continue working in what is often an intolerable workplace.

Mr ROWALLAN - Because of that intensity and because of how fatiguing it is, the only way we're going to advance it is by thinking outside the square in terms of what we're doing.

At the moment they have created these shift patterns to try to squeeze them into a 38-hour week that's averaged out over a 64-day roster weekly. They've factored all these sorts of things that have been created to try to squish it into a normal 38-hour working week that is averaged out.

As a dispatcher, my shifts average out to 40 hours a week. As I say, I will work 43 hours in a block as things currently stand.

We need to say, 'Hang on, why are we even trying to fit this into a 38-hour week?' We should be saying, 'What is the maximum hours that people should be working in these kinds of roles', and this applies to the hospital nurses as well. Even if they are doing seven eight-hour shifts in a row, which I believe some of them do, depending on the roster, are they finishing on time? I'm not sure that they are. Even if they did seven, eight-hour nights in a row is also not manageable.

You need to think outside the square. We need to sit there and say, 'Okay, what is the maximum length of shift?' Bearing in mind that it might be extended, especially for the paramedics. It does get extended for dispatchers as well at times if we are busy, as happened on Monday night. Two people stayed back three hours because we were short. The supervisor stayed back for 1.5 hours or so from day shift. So, the three people that finished late, the nurse coordinator also finished 2.5 hours late. So, four people finished later than they should have in the communications centre, not just on the road.

CHAIR - We have to finish up now. You have a rich source of information in your submission which we will refer to.

I want to clarify something about the Monday night shift issue that you talked about from this week. You said there seven to eight P1s that came in. What escalation level was that?

Mr ROWALLAN - We started at escalation level 4 and we remained at escalation level 4 until about 5 a.m.

CHAIR - Okay. How often do you hit escalation level 4?

Mr ROWALLAN - It is a daily basis almost. If you don't get to escalation level 4, that is a surprise. It is considered to be a surprise if you don't.

CHAIR - That is shocking information.

Mr ROWALLAN - I would say it is not every single day.

CHAIR - Toby, thank you for everything you have provided to the committee. Is there anything you want to say - last thoughts in addition to things that you've talked about in your submission?

Mr ROWALLAN - I have had a number of comments from paramedics who sent me information. There's not really time to go through those in detail. In terms of the document that I sent through at the same time as my submission -

CHAIR - That's right, the 10 points of policy making.

Mr ROWALLAN - Yes, by Jeremy Sammut. I've just got the two pages from the year, I don't know if people will necessarily consider it relevant considering it's 2009, but I think it's highly relevant because it's gotten worse from then. It's not better. It's not like it's an old situation that can be dismissed, because it's the same situation but worse. What's really happening is when you look at the points in the document and what it's talking about, they haven't been addressed. They haven't been addressed since 2009 and all it's done is gotten worse.

The Health department has started a review, which you are probably aware of, of course. I attended one of the Zoom meetings that Ambulance Tasmania hosted where they talked about some of the things they are investigating. I'm not going to disagree with the aims of that review because there are a lot of things that they are looking at that are worth looking at and worth considering. What worries me is this demand and the expected demand is all predictable. It's all there in statistics and they can analyse them and they can see what's going to happen and where things are going to get worse. Despite this knowledge, despite the fact that people who are looking at this data know this, we're just getting worse.

Our case load demand is going up every year for ambulance. It's going up somewhere between 4 per cent to 7 per cent per year; most years I believe it's been around 7 per cent. We've consequently had a significant expansion in terms of the resources we are supposed to have. We've had a recent review where they've recommended a drastic expansion in terms of the available crewing and an additional number of stations that is quite extraordinary.

CHAIR - What was the date of that review again?

Mr ROWALLAN - That was done by RH and that was completed in late 2022, maybe early last year. It has recommended a huge amount of additional stations all around the state. If we had those stations now that would be great, but at the moment with the amount of sick leave that we have and crews not fully staffed, it would be an enormous number of paramedics that would need to be employed to just staff these extra stations. We'd almost have to double our staffing numbers, which would be an enormous pressure on training as well, of course.

This is what they can see from the data. This dramatic change is required to manage our demand and future demand, and yet here we are, 2009, and if they wrote that report, it'd just be a copy and paste.

CHAIR - I am reading finding number 5: 'Hospital overcrowding is not caused by GP-style patients swamping emergency departments'.

Mr ROWALLAN - No, it is not. The patients that are not sick go to the waiting room. We do have people that call because they think that they'll be seen quicker if they get an ambulance. They won't. They'll be seen based on how sick they are. I hope for their sake, they're not seen quicker because we don't want them to be sick. It's not the people that need to see a GP that are causing the problem. The demand still affects it a little bit.

We might be on scene with someone who is a lower acuity patient who doesn't need to be rushed to hospital, and that will prevent that crew going to something that is more life threatening, but there is always potential potential for someone who comes in as a priority 4 case even and we can miss something. It might be because the caller doesn't report an important symptom, so we don't know and we get there and the crew discovers actually something else from what we were told is going on and is much worse than we initially thought. That does sometimes happen, especially when we are under-resourced and under-staffed. The chance for that sort of mistake to occur increases.

CHAIR - We've got to finish now. Did you have actual comments from other people that you wanted to table to the committee because we could do that if that was something you wanted to do?

Mr ROWALLAN - I can send that through if you like.

CHAIR - Please do. We will be happy to receive that. Thank you so much Toby for the work that you do and for coming and giving us such extensive and rich detail about the situation and the pressures that you work under every day. We acknowledge the work you other dispatchers do. It is part of the health system that people don't see and yet you are the critical people that organise all the moving parts and it's such important work. Thank you.

Mr ROWALLAN - Thank you.

CHAIR - I want to remind you before you leave that what you said today is covered under parliamentary privilege but when you leave here you won't be covered by the same privilege if you say something which could be defamatory or result in potential court action you wouldn't be covered.

THE WITNESS WITHDREW.

The committee suspended at 4.51 p.m.