2024 (No. 30)

PARLIAMENT OF TASMANIA

House of Assembly Select Committee on

TRANSFER OF CARE DELAYS (AMBULANCE RAMPING)

MEMBERS OF THE COMMITTEE

Mrs *Alexander* (*until 14 February 2024*)
Mr *Behrakis* (*from 2 November 2023*)
Ms *Dow* (Deputy Chair until *14 February 2024*
continued as substantive member from *13 June 2024*)
Ms *Haddad* (Deputy Chair *from 13 June 2024*)
Ms *Johnston* (*from 13 June 2024*)
Ms *O'Byrne* (*until 14 February 2024*)
Dr *Woodruff (Chair)*
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Mr *Young (until 2 November 2023)*

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CHAIR'S FOREWORD

On behalf of the House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping), I am proud to present the Committee's final report.

Community concerns about the impacts of ambulance ramping had been growing for some years before this Inquiry was established, even in the absence of detailed publicly available data. These concerns reached new heights following the tragic death of Ms Kathleen Schramm while ramped at the Royal Hobart Hospital in November 2022, after this situation was courageously shared by her family with the public.

In August 2023, the Coroner released a report into the death of Anne Pedler, who died after being ramped for eight hours at the Launceston General Hospital. In his report, Coroner Robert Webster expressed pessimism about the trajectory of this issue, noting the Tasmanian Health Service's response to the incident was "silent about what THS proposes to do about ramping", and shared his concern that "cases like this one will continue to occur."

These statements resonated with many Tasmanians and prompted calls to establish this Inquiry – a step unanimously supported by the House of Assembly.

The ambulance ramping Inquiry received extensive written and oral evidence from patients and their families, healthcare workers, experts, unions, professional health bodies, advocates, and the State Government.

The stories people shared with this Inquiry were often shocking and deeply distressing. Individually, each person described an experience of trauma, risk, pain, stress, suffering, moral injury, loss of careers and – in some terrible cases – loss of life.

Collectively, their voices shone a spotlight on the serious failures of a health system that has been unresponsive to changing circumstances, and significantly under-resourced across years to meet the increased community need. So much so, entrenched ambulance ramping has become an ongoing structural feature of our health system when just a decade ago it was an anomaly. The evidence presented to the Inquiry makes the case for an urgent need to take ambitious action and reverse the situation.

The Committee acknowledges the bravery of those who chose to share their personal experiences through this Inquiry. Your contributions have been invaluable. We also acknowledge the many others who experienced the harms occurring in the health system, but who were not able to – or did not feel comfortable to – provide evidence.

As well as numerous individual stories, the Inquiry heard important evidence that comprehensively and forensically addressed systemic problems in the provision of Tasmanian healthcare. We thank the wide range of experts, advocates and stakeholders who greatly assisted us with their insights and information. We also thank the Department of Health and Ambulance Tasmania for their cooperation, and for the extensive work undertaken by their staff to provide the Inquiry with data and detail never previously available.

While there have been many reviews into Tasmania's health system over recent years, none have provided the wider public or the Parliament with such a clear, direct, and comprehensive insight into the rapidly growing challenges facing our health system. In itself this has been an important outcome and has helped lay the foundations for change. It has also provided the Inquiry with a strong evidence base for our findings and recommendations.

This report contains 9 major findings and 101 detailed findings. Together these describe a health system in serious trouble. A decade ago, ambulance ramping in Tasmania was an uncommon event arising from major surges in hospital demand. Only a small subset of patients with relatively minor conditions were affected. This situation has rapidly changed. In recent years we have seen ambulance ramping reach extreme levels of frequency and duration. It has also increasingly affected patients who are very unwell and/or at greater risk.

This report makes findings about the causes of ambulance ramping. These include those within hospitals – such as insufficient hospital capacity; inadequate staffing; inefficiencies in patient flow; and inability to discharge patients in a timely way. They also include factors external to the hospital, such as deficiencies in primary and community care, access to NDIS support, and the availability of aged care beds. The Government's response to these challenges has to date been inadequate. This fact is evident in the decade-long trend of an increase in ambulance ramping.

This report also makes findings about the effects of ambulance ramping. It shows that while ramping is a symptom of problems in the wider health system, it is also a driver of further negative effects through the system. These include the greater risk and more frequent harms to patients; detrimental impacts on staff; longer ambulance response times to call outs; and greater challenges for the Emergency Department and other hospital functions.

We acknowledge the findings of this Inquiry paint a very grim picture of the state of Tasmania's health system. We know many Tasmanians – especially those with direct exposure to this situation – have begun to feel that the challenges in health are intractable and further deterioration is inevitable. This view is entirely understandable given the trajectory of recent years.

However, this Inquiry didn't just hear about problems in health – it also heard repeated ideas for possible solutions. The evidence showed that, despite the challenges, there is a realistic, achievable path to reversing the trend of declining patient outcomes and moving towards improvements.

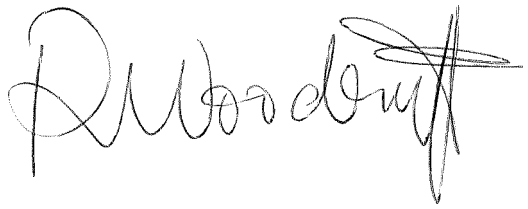
The Inquiry makes 6 major recommendations, and 35 detailed recommendations. These include accelerating planned increases in hospital capacity; doing more to address short staffing; specific actions to improve patient flow and timely discharge; expanding measures to keep people out of hospital; and extra support for health workers dealing with the mental health issues of intense workplace pressures.

Critically, implementation of these recommendations at the scale and pace required for success will require a significant increase in resourcing.

In addition to uncovering what is happening in the health system, an important part of this Inquiry dwelt on the government's understanding of, and reporting on, its management of ambulance ramping and resulting impacts. The Inquiry heard that much information is internally reported within the Department of Health, but not made public. We identified significant gaps in the data being collected, especially in relation to the specific circumstances of ambulance ramping. Addressing these issues and transparently reporting more data – including historic data – are basic steps that should be implemented immediately.

Finally, we note the evidence presented to this Inquiry regarding issues with procedures for the reporting of deaths at the Launceston General Hospital. Nurses Tom Millen and Amanda Duncan provided powerful evidence never before made public, and their significant concerns about the conduct of a former employee of the hospital. Their testimony led to the Department of Health establishing an independent panel of experts to examine this issue. Given the Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals Review has extensively considered these matters, this Inquiry makes no findings or recommendations about them.

In closing, I wish to acknowledge the members of the Committee for their hard work, invaluable contributions, and collaborative working relationship throughout this important Inquiry. I acknowledge the work of previous Committee members, the Member for Bass Michelle O'Byrne and former Member for Bass Lara Alexander.



Sincerely,

Dr Rosalie Woodruff MP
Chair

11 November 2024

MAJOR FINDINGS

1. **Over the past decade the frequency and duration of ambulance ramping in Tasmania has rapidly increased.**

2. **Ambulance ramping is both a symptom of problems in the wider health system, and a cause of further negative effects in the system.**

3. **The direct cause of ambulance ramping is access block, which in turn results from insufficient hospital capacity, inadequate staffing, inefficiencies in patient flow, and inability to discharge patients in a timely way.**

4. **A range of external factors influence access block, including availability of community and primary care, National Disability Insurance Scheme support, and aged care.**

5. **The rapid increase in ambulance ramping has resulted in higher risks and more frequent adverse outcomes – including death – for patients.**

6. **Healthcare staff, especially paramedics and Emergency Department staff, are suffering significant negative impacts on their mental health and wellbeing due to ambulance ramping.**

7. **The State Government's response to the causes and effects of ambulance ramping has been inadequate.**

8. **The State Government's approach to ambulance ramping data collection and reporting has been deficient and lacking in transparency.**

9. **Achieving meaningful long-term improvements in ambulance ramping, its causes, and its effects will require ambitious, system-wide action from the State and Federal Governments, supported by significant increases in State resourcing.**

DETAILED FINDINGS

CONTEXT AND CAUSES OF AMBULANCE RAMPING

1. Over the past decade the frequency and duration of ambulance ramping in Tasmania has dramatically increased.

2. Ambulance ramping is the result of whole of health system failures.

3. Ambulance ramping has itself caused and further exacerbated issues in the health system.

Access Block

4. The major direct cause of transfer of care delays is access block.

5. Tasmanian hospitals are experiencing increasingly high levels of access block.

6. The observed increase in patients with low acuity accessing Emergency Departments, who do not need a hospital bed, does not significantly contribute to access block and as a result does not influence transfer of care delays.

7. Given limits to hospital resources, competition can occur for bed access between Emergency Department patients and patients awaiting scheduled surgery, aggravating access block and elective surgery waitlists.

Hospital Capacity and Patient Flow

8. Insufficient hospital bed capacity is a fundamental problem that contributes to access block.

9. The major Tasmanian hospitals have been running, for years, close to or above capacity, resulting in them operating without surge capacity.

10. Over-capacity hospitals are the result of hospital attendances and admissions increasing faster than bed numbers, further influenced by the availability of staff to service beds, and the ability to discharge patients in a timely manner.

11. Hospitals continually operating close to, at, or above capacity negatively impacts staff training and teaching, and reduces the ability for staff to provide quality, holistic care to patients.

12. The Tasmanian Health Service *Statewide Access and Patient Flow Program* currently lacks hospital emergency tracking targets and performance indicators, as well as commensurate funding.

Exit Block

13. The inability to discharge patients in a timely way ('exit block') exacerbates access block by reducing the number of available hospital beds, and impacts on other hospital functions.

14. Exit block is primarily caused by delays in finding appropriate care for patients outside of hospitals. Blockages occur in identifying appropriately equipped residential aged care, disability care, in-home supports and housing.

15. The admission process does not include adequate discharge planning with the patients, their family/guardians, or hospital staff, which often contributes to exit block.

16. Aged care homes sometimes have beds that become available but are not used to discharge hospital patients into because there is no system to alert hospital staff.

17. The model of care in aged care facilities does not always provide the comprehensive medical care that patients need on site, which is a factor that delays patient discharge.

18. Limited operating hours for specialists, pharmacy, diagnostics, allied health and other key hospital services, contributes to delays in the timely discharge of patients.

19. Patients awaiting hospital-dispensed medications can lead to long waits for discharge.

Staffing Shortages

20. Staffing shortages are a major factor that contribute to transfer of care delays.

21. Understaffing, especially in nursing and allied health, negatively impacts on patient care, leading to longer hospital stays for patients and a reduction in bed availability.

22. Tasmanian hospitals and Ambulance Tasmania would benefit from more permanent staffing contracts.

23. Many staff are leaving the Tasmanian Health Service for other states or private providers due to a lack of parity for pay and conditions.

24. There is a shortage in available cleaning staff to prepare vacant beds to ensure the efficient transfer of patients to wards from the Emergency Department.

Resourcing

25. Transfer of care delays are a symptom of an underfunded Tasmanian health system that has not kept pace with community healthcare need.

26. The over-reliance on locum doctors and agency staff is an enormous expense to the Tasmanian Health Service.

27. The State Government has allocated insufficient funding to the level of nursing, paramedic, allied health and ancillary staff required to adequately run Tasmanian hospitals to national benchmarks.

28. Effectively dealing with the root causes of ambulance ramping will require significant additional investment by the State Government.

Primary and Community Care

29. A lack of sufficient and adequate primary and community care means many Tasmanians are unable to seek health treatment in a timely manner. This results in people becoming more unwell, and greater numbers of avoidable hospital admissions.

30. Nurse practitioners, community health workers, rural generalists, and allied health staff, are currently underutilised in community and primary care provision across Tasmania.

31. Tasmania currently lacks a strategy to increase the use of nurse practitioners, including training and employment pathways.

32. Tasmania does not have a rural healthcare workforce development plan which has exacerbated staff shortages and impaired access to services in regional Tasmania.

33. The lack of adequate investment in primary and community health in Tasmania, by state and federal governments, is leading to avoidable hospital admissions and additional pressure on ambulance callouts and Emergency Departments.

34. The lack of available primary and community care, especially in regional areas, has resulted in increased ambulance callouts, and paramedics being forced to undertake community healthcare duties.

35. Bulk billing rates and lack of access to General Practitioners can lead to people visiting Emergency Departments in search of free or subsidised healthcare. Although this is not a significant contributor to ambulance ramping, it is an increased burden on the operations and resources of ambulance services and Emergency Departments.

36. Avoidable hospital readmissions are occurring because people are unable to access appropriate post-discharge care in the community. These readmissions place further strain on the hospital system, contributing to access block and transfer of care delays.

37. The current general practice primary care model may no longer be entirely suitable for the Tasmanian community and its decentralised population.

38. Clinical staff working within aged care facilities currently do not have the authority to refer patients to the Community Rapid Response Service for necessary care. This leads to an increased reliance on ambulance and Emergency Department services.

39. Extended care paramedics and community paramedics can assist in keeping aged care patients in facilities, and out of Emergency Departments.

40. The Hospital in the Home program is having a positive effect on reducing the number of patients requiring hospital-based care. It currently does not operate state-wide and has limits on patient numbers.

41. Telehealth in Tasmania is not being fully utilised in terms of reach and usage and does not properly focus on consumer needs.

42. Tasmania's district hospitals are currently underutilised and understaffed, and lack strategic planning including of infrastructure, workforce and clinical services.

EFFECTS OF AMBULANCE RAMPING

Patient care and outcomes

43. Transfer of care delays directly and negatively affect the treatment of patients, leading to increased morbidity and mortality rates.

44. The scope of practice for paramedics is not designed for hospital-based care.

45. The care available to ramped patients is limited to that available within the scope of practice for paramedics. This means a ramped patient, compared to an equivalent Emergency Department waiting room patient, is at greater health risk because they cannot access the full range of necessary medications (including pain relief and antibiotics) and interventions (including diagnostic tests) that are available within the Emergency Department.

46. Ambulance ramping delays increase the risk of a patient suffering an adverse event. There is a ten percent greater chance of dying within seven days for people who have experienced ambulance ramping.

47. There has been a significant increase in the number of Category 2 (very unwell) patients who have been subjected to ramping despite the risks to their health.

48. Transfer of care delays lead to a lack of appropriate spaces to assess and treat patients, leading to distress and a loss of dignity and privacy for patients.

49. Some people in the community avoid seeking emergency care when they really need it due to fear of experiencing ambulance ramping, or because they feel guilty about potentially taking ambulance resources from others in need.

50. A lack of 24/7 pathology and radiology services can result in adverse outcomes due to the delay in care from waiting for results.

Ambulance response times and availability

51. There has been a significant increase in demand for ambulance services in Tasmania in recent years.

52. Ambulance ramping leads to fewer ambulances being available to respond to ambulance callouts, leading to delayed ambulance response times (including for emergency calls).

53. Longer ambulance ramping times are associated with increased pain and suffering for patients and greater risk of adverse health outcomes.

54. Transfer of care delays have a disproportionate negative impact on rural communities. Ambulances from these communities that are ramped at major hospitals leave regions without local ambulances available to respond to callouts.

55. Ambulance ramping constrains paramedics to the hospital in order to care for ramped patients. This can result in single paramedics having to attend jobs without back up.

56. Ramping increases costs to the Tasmanian Health Service, including the cost of having paramedics not fulfilling their primary role.

57. Inadequate staff numbers in Ambulance Tasmania are exacerbating the effects of transfer of care delays and increased demand for ambulance services.

58. The operational effectiveness of Ambulance Tasmania would benefit from having more permanent staffing contracts.

59. Community care paramedics, extended care paramedics, secondary triage, telehealth and other measures are showing some signs of mitigating the effects of ambulance ramping and delays in ambulance response times.

Wellbeing of staff

60. The ambulance ramping experienced in Tasmania's hospitals, has directly and seriously impacted the mental health and wellbeing of many emergency healthcare staff.

61. Ambulance Tasmania staff have experienced extreme emotional pressure, mental health impacts, and moral injury through:

- being forced to choose between following their scope of practice or allowing patients to access necessary medical care;
- being stuck on the ramp and not being able to work in their role as emergency responders in the community;
- being forced to care for multiple patients at a time on the ramp due to the requirement for other crews to respond to emergency calls, or pressure from within Ambulance Tasmania management;
- hearing Priority 0 and Priority 1 triple zero calls remaining unanswered for long periods;
- experiencing extreme pressure and stress when trying to manage and dispatch ambulance resources;
- attending ambulance callouts as a sole paramedic without necessary support;
- receiving verbal abuse and the risk of violence from patients;
- working without meal breaks and forced overtime; and
- working under increased fatigue and the associated personal and patient risks.

62. Tasmanian Health Service staff in Emergency Departments have experienced extreme emotional pressure, mental health impacts, and moral injury through the increased workload and workplace conditions associated with transfer of care delays.

63. As a consequence of negative workplace impacts from ambulance ramping, many Ambulance Tasmania and Tasmanian Health Service staff in Emergency Departments have suffered stress, anxiety, depression, post-traumatic stress disorder and burnout. This has resulted in:

- increased sick leave and worker's compensation claims;
- staff reducing hours to cope; and
- staff leaving Ambulance Tasmania and the Tasmanian Health Service because they are no longer able, or willing, to work in emergency healthcare.

64. The impact of extensive ambulance ramping has resulted in Emergency Departments and Ambulance Tasmania losing senior skilled staff, and a loss of corporate knowledge and experience.

65. Longer transfer of care delays are causing conflict between ambulance and Emergency Department staff around the provision of optimal care for patients, in what has historically been a collaborative work environment.

66. Paramedics regularly feel pressure from Ambulance Tasmania or Emergency Department staff to perform tasks outside of their scope of practice, and duties, while they are on the ramp.

67. Ambulance Tasmania and Tasmanian Health Service staff currently do not have sufficient psychological supports in the workplace.

Impact on Emergency Department and other hospital functions

68. Ambulance ramping has a significant negative impact on the workload of Emergency Department staff.

69. Ambulance ramping at times, interrupts the normal workflow and triaging system of the Emergency Department.

70. Transfer of care delays add additional pressures on Emergency Department clinicians and the quality of care they are able to provide patients. Older people, and people with neurodegenerative conditions, are especially impacted.

71. When access block occurs in a hospital, ambulance ramping results in more patients needing a bed in the Emergency Department. This is not a desirable situation, for the health of the patients or the functioning of the Emergency Department.

72. The use of clinically inappropriate spaces to manage increased ambulance ramping demand, has resulted in increased risk of adverse health outcomes for patients.

73. Ambulance ramping has resulted in ramped patients and Emergency Department patients being subjected to unsafe nurse and paramedic to patient ratios.

74. Ambulance ramping has whole-of-hospital impacts, including via:

    a. The condition of ramped patients deteriorating, increasing demand for hospital care;

    b. The expectation that patients on wards are moved more quickly from admission to discharge to make more beds available, adding pressure to staff;

    c. Cancellations of scheduled procedures to create more bed space for ramped patients; and

    d. The allocation of hospital resources towards managing ambulance ramping, diverting resources from other parts of the hospital.

DATA COLLECTION AND REPORTING

75. There are existing deficiencies with data collection and transparency of data in the Tasmanian Health Service.

76. Current data capture systems in the Tasmanian Health Service are inadequate, burdensome and do not provide an intuitive, interlinked network of communication.

77. Inadequate data collection has resulted in poor statistical accuracy regarding the work and patient flow through the Tasmanian Health Service, including in Emergency Departments, ambulances and ramps.

78. Data collection needs to be accurate, easily available online, and provided in near to real-time to provide a useful measure for day-to-day operations and long-term improvements.

79. Moving patients through the healthcare system would be greatly assisted by having system components that are compatible and able to detect and predict flow blockages before they occur.

THE STATE GOVERNMENT'S RESPONSE

80. Evidence suggests that while the government has done some work in response to ambulance ramping, it falls short of the whole of system change necessary to address access block, improve patient flow through the hospital, and to improve the delivery of ambulance service in the community.

81. Early evidence indicates the state government's 60-minute transfer of care protocol, announced in February 2024, has had a positive effect on the time taken to transfer patients from the care of Ambulance Tasmania to Tasmanian Health Service staff and has removed ambulances from the ramp in a more timely manner.

82. The State Government's current transfer of care protocol has not, of itself, improved the length of time patients are spending in Emergency Departments.

83. There are concerns the transfer of patients under the protocol from Ambulance Tasmania staff to Tasmanian Health Service staff is increasing pressure on nursing and clinical staff in the Emergency Department.

84. The transfer of care protocol has not addressed patient flow issues through the Emergency Department, inpatient wards and discharge processes.

85. Without a focus on whole-of-system reforms, the transfer of care protocol only shifts the problem of access block from the ambulance ramp into the Emergency Department, creating additional pressures there.

86. Staffing resources in the Emergency Department have not been increased to manage the influx of extra patients from the ramp needing care in the Emergency Department due to the transfer of care protocol.

87. A failure to adequately increase staffing to accommodate the transfer of care protocol has resulted in additional tensions between Emergency Department and Ambulance Tasmania staff, and additional pressures and stress on Emergency Department staff.

88. The development of new models of care across the health system would benefit from additional investment in:

- Hospital in the Home;
- Urgent Care Clinics;
- extended care paramedics;
- district hospitals and community health centres; and
- increased data collection.

MEASURES TAKEN BY OTHER JURISDICTIONS

89. Telehealth and virtual health services can reduce the impact on hospital facilities by providing access for care outside of physical General Practitioners, ambulance and hospital settings.

90. There are insufficient telehealth and virtual health services in Tasmania.

91. The availability of telehealth and virtual health services particularly impacts on regional Tasmania, where there is difficulty accessing physical health services.

92. Multi-disciplinary out of hospital care teams and Hospital in the Home services alleviate pressure on hospitals by providing more holistic care, and thereby decreasing hospital presentations.

93. Extending the role and scope of practice of paramedics would provide them with an increased range of multi-disciplinary emergency skills. This would allow them to care for people in both homes and facilities, reducing avoidable hospital admissions and use of ambulance services.

94. Increasing the number of extended care paramedics in the community would decrease admissions to the Emergency Department via ambulance through providing care directly in the community setting.

FURTHER ACTIONS THAT CAN BE TAKEN

95. A number of reviews and reports exist regarding Ambulance Tasmania, ambulance ramping and state Emergency Department service provision. Some recommendations from these have not yet been implemented.

96. In addition to other findings of this report, the State Government has a further range of opportunities to reduce ambulance ramping that are currently not being employed:

- consistent triage policies and procedures across Tasmanian hospitals;
- strategic review of community health centres, including infrastructure, workforce and clinical services; and
- a review of the workflow and structure of the Tasmanian Health Service.

97. In addition to other findings of this report, the State Government has opportunities to improve patient flow throughout hospitals by introducing Nurse Navigator positions in every major hospital Emergency Department and expanding this role to include discharge planning at the time of patient admission to the Emergency Department.

98. A shortage of community rapid response services, community dementia teams, and 24/7 palliative care services, are increasing pressure on hospitals.

99. Paramedics currently operate without procedures for end of shift protections.

100. The Tasmanian health system and emergency services would benefit from the establishment of a Chief Paramedic Officer.

101. There is insufficient investment in telehealth services; extended care paramedics; specialised community support teams; and secondary triage, all of which are initiatives that would help alleviate transfer of care delays.

MAJOR RECOMMENDATIONS

1. **A significant increase in resourcing must be provided to the Tasmanian health system to fund the ambitious action required to address ambulance ramping, its causes, and its effects.**
2. **Plans to expand hospital capacity must be brought forward to ensure projected need is met.**
3. **Short staffing across the health system must be urgently addressed to mitigate the causes and effects of ambulance ramping.**
4. **Measures to keep patients out of hospital should be expanded as rapidly and safely possible.**
5. **Urgent action must be taken to better support the health, mental health, and wellbeing of staff – especially Ambulance Tasmania and Emergency Department staff.**
6. **Immediate action is required to improve transparency around, and understanding about, the extent of ambulance ramping and its effects on harmful health outcomes.**

DETAILED RECOMMENDATIONS

CAUSES OF AMBULANCE RAMPING

The Committee recommends the State Government:

1. Bring forward the timeline for the Department of Health's masterplans for acute hospitals to have a delivery deadline of 2035.
2. Commit to a goal – supported by appropriate funding and operational plans – of reducing patient occupancy rates in major Tasmanian hospitals to 90%.
3. Develop a comprehensive plan to ensure the efficient and effective use of capacity in district hospitals.
4. Ensure all major hospitals employ a dedicated Emergency Department Navigator position to coordinate patient flow in and out of the Emergency Department.
5. Increase the number of allied health staff in public hospitals and expand shift coverage to match the operating hours of Emergency Departments.
6. Expand the availability of pathology and radiology services such that they are in line with the operating hours of hospital Emergency Departments.
7. Undertake a review of the number of hospital cleaning staff required to ensure beds are cleaned and available for use and increase investment appropriately.

8. Appoint a person within the Department of Health with specific oversight and reporting on system-wide initiatives to address patient flow.

9. Expand, as rapidly as safely possible, proven effective measures for keeping patients out of hospital, including at-home care such as *Hospital in the Home*, and the use of community paramedics and extended-care paramedics.

10. Work with aged care providers to develop an interface system that gives hospital staff immediate intelligence of available beds in aged care facilities.

EFFECTS OF AMBULANCE RAMPING

The Committee recommends the State Government:

11. Commit to increasing Emergency Department staffing to levels that ensure safe and reliable care of patients.

12. Commit to increasing Ambulance Tasmania staffing to ensure ambulances reliably respond to incidents within safe timeframes.

13. Undertake — or collaborate with another party to undertake — a population-level assessment of the preventable harm caused to patients due to transfer of care delays and longer ambulance response times.

14. Expand the operating hours of the Ambulance Tasmania secondary triage service.

15. Review, in consultation with staff, current protocols governing clinical management of patients subject to transfer of care delays, and their use in practice. Implement changes to improve outcomes for patients and staff.

16. Support the Department of Health to undertake — in consultation with key stakeholders — an assessment of human resources employment including, but not limited to, contract type, retention, recruitment, pay scales, rostering, breaks and entitlements.

DATA COLLECTION AND REPORTING

The Committee recommends the Tasmanian Health Service:

17. Make data publicly available in relation to:
    a. transfer of care delays, by hospital and level of bed availability;
    b. the number of residential aged care patients ready to be discharged but unable to be transferred to appropriate care; and
    c. the number of patients in the Emergency Department who are diverted to urgent care centres.

18. Expand the data available describing patient care and hospital procedures, facilitate real-time updates, and provide access to historical data.

19. Ensure all data systems allow for patients to be recorded as having a status and/or location of 'transfer of care delay'.

20. Publish online, as soon as available, the information about transfer of care delays contained within Ambulance Tasmania's monthly reports.

21. Ensure the Safety Reporting and Learning System is upgraded to make it accessible for staff to report any incidents or concerns.

22. Work to ensure the data systems between all health areas 'talk' to each other so that a whole-of-system picture is available to staff.

23. Ensure both the Tasmanian Health Service and Ambulance Tasmania have access to whole-of-system hospital data to better understand where blockages to patient flow are occurring.

THE STATE GOVERNMENT'S RESPONSE

The Committee recommends the State Government:

24. Expand the Hospital at Home program to be available to all Tasmanians.

25. Increase funding for Emergency Department staff to account for the increase in workload resulting from the 60-minute offload policy.

MEASURES TAKEN BY OTHER JURISDICTIONS

The Committee recommends the State Government:

26. Commit to a full whole-of-system assessment of the Tasmanian Health Service to provide a thorough scope for change across all levels of the system.

27. Appoint a person with oversight of patient flow with the responsibility for identifying and reporting on system-wide initiatives to address patient flow.

28. Invest in, and expand, the extended care paramedic and community care paramedics programs, with a focus on assisting patients in aged care facilities.

29. Undertake an assessment of human resource employment matters including, but not limited to, contract type, retention, recruitment, pay scales, rostering, breaks and entitlements.

30. Continue to work with the Federal Government to improve primary and community care alternatives to improve hospital flow, including access to General Practitioner's services and the discharge of aged care and National Disability Insurance Scheme patients.

FURTHER ACTIONS THAT CAN BE TAKEN

The Committee recommends the State Government:

31. Fully implement the recommendations of the *Independent Review of Tasmania's Major Hospital Emergency Departments* within the recommended timeframes.

32. Ensures every major hospital has 24/7 Nurse Navigator positions in Emergency Departments, with this role to include discharge planning for admitted patients.

33. Substantially expand community rapid response, community dementia teams, and 24/7 palliative care services.

34. Establish a Chief Paramedic Officer position in the Tasmanian Health Service.

35. Funds the Auditor-General to undertake a reassessment of culture and leadership effectiveness within the Tasmanian Health Service.

1. INQUIRY PROCESS

BACKGROUND

1.1. Transfer of care delays, also commonly referred to as ambulance ramping, offload delay or patient off-stretcher time delay, is a problem experienced by many states and territories around Australia.

1.2. 'Transfer of care delay' is where paramedics are unable to transfer the care of their patients to a hospital staff member within 15 minutes of arrival in an ambulance. Any transfer after more than 15 minutes is considered a delay that is unacceptable.[1]

1.3. There has been a national trend of increased Emergency Department (ED) attendances. In Tasmania, ED attendances have grown in the past ten years by 31,651 between 2011-12 and 2021-22, an increase of 22.4 percent.[2]

1.4. Data from the Tasmanian Department of Health shows an increase in transfer of care delays for patients arriving by ambulance in the years from 2015-16 to 2022-23.[3] In 2015-16, across Tasmania's four major hospitals, 9 percent of patients arriving by ambulance waited longer than 15 minutes. By 2022-23, this delay was being experienced by 39.8 percent of patients.[4]

1.5. Over the same time period, there has also been an increase in patients waiting longer than 30 minutes to be transferred, with data showing an increase from 5.7 percent to 32.6 percent.

1.6. Transfer of care delays are more common in the state's two major hospitals, the Royal Hobart Hospital (RHH) and the Launceston General Hospital (LGH).[5]

1.7. There are multiple causes for transfer of care delays, including hospital capacity and patient flow issues, staffing and funding issues, as well as gaps in primary and community care.

1.8. Evidence from both this Inquiry and from other jurisdictions shows that fixing transfer of care delays will require whole-of-system changes to improve patient flow and hospital capacity.

1.9. The Committee notes there have already been a significant number of reviews relevant to this space including the '*Major Hospital Emergency Department Review to Improve Patient Access and Flow – Launceston General Hospital and Royal Hobart Hospital*,' the Report of the Auditor-General No. 11 of 2018-19 '*Performance of Tasmania's four major hospitals in the delivery of emergency department Services*' and the most recent report from Debora Picone AO titled '*Independent Review of*

[1] Letter from the Department of Health, dated 10 November 2023, p. 2., Appendix C.
[2] Australian Institute of Health and Welfare.
[3] Letter from the Department of Health, dated 10 November 2023, p.2., Appendix C.
[4] Letter from the Department of Health, dated 10 November 2023, p.2., Appendix C.
[5] Letter from the Department of Health, dated 10 November 2023, p.2., Appendix C.

Tasmania's Major Hospital Emergency Departments.' A list of existing reviews is available in Appendix D.

1.10. The Committee notes the aforementioned recently published '*Independent Review of Tasmania's Major Hospital Emergency Departments*' and the recommendations contained within.[6]

1.11. Implementation of the recommendations of these many reviews would provide a clear start in addressing the complex problem of transfer of care delays.

APPOINTMENT AND TERMS OF REFERENCE

1.12. The House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping) was established on 9 August 2023 with the following terms of reference:

> (1) (a) *the causes of transfer of care delays, acknowledging Federal and State responsibilities;*
> *(b) the effect transfer of care delays has on: —*
> *(i) patient care and outcomes;*
> *(ii) ambulance response times and availability;*
> *(iii) wellbeing of healthcare staff;*
> *(iv) Emergency department and other hospital functions;*
> *(c) the adequacy of the State Government's data collection and reporting for transfer of care delays;*
> *(d) the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures;*
> *(e) measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;*
> *(f) further actions that can be taken by the State Government in the short, medium and long-term to address the causes and effects of transfer of care delays; and*
> *(g) any other related matters incidental thereto.*
> *(2) The number of Members appointed by the House to serve on the Committee be six: Two nominated by the Leader of Government Business; two nominated by the Leader of Opposition Business; one nominated by the Leader of Tasmanian Greens Business; and Lara Alexander MP.*
> *(3) The Committee report by 28 March 2024.*

1.13. On 19 October 2023, the Committee Chair, moved in the House of Assembly that the reporting date for the Committee be extended until 30 April next. The motion was agreed to by the House.

[6] 'Independent Review of Tasmania's Major Hospital Emergency Departments', 7 May 2024, Chair – Adjunct Professor Debora Picone AO, https://www.health.tas.gov.au/sites/default/files/2024-05/independent_review_of_tasmanias_major_hospital_eds.pdf

1.14. The Committee had not yet reported when the House of Assembly was dissolved on 14 February 2024. On 13 June 2024 a new Select Committee on Transfer of Care Delays was established by the Fifty-first Parliament. This new Committee was ordered to have access to all evidence and papers received from the Committee of the same name in the Fiftieth Parliament. The new terms of reference set that the Committee report by 12 September 2024.

1.15. The new Committee first met on 26 June 2024 with the following Members: Dr *Woodruff* MP (Chair), Ms *Haddad* MP (Deputy Chair), Mr *Behrakis* MP, Ms *Dow* MP, Ms *Johnston* MP and Mr *Wood* MP.

CONDUCT OF THE INQUIRY

1.16. The Committee resolved to invite, by way of advertisement on the Parliament of Tasmania website and in the three major Tasmanian newspapers, interested persons and organisations to make a submission to the Committee in relation to the Terms of Reference.

1.17. The Committee during the Fiftieth Parliament received 74 submissions and held 9 public hearings, including one in Launceston. The Committee heard from a total of 43 witnesses in both public and in-camera hearings.

1.18. The Committee attended a site visit at the Launceston General Hospital on 8 November 2023.

1.19. Following the prorogation of the Fiftieth Parliament on 14 February 2024, the Committee ceased to exist. A new Committee was established on 13 June 2024 by the Fifty-First Parliament which was given access to the previous Committee's evidence and given a reporting date of 12 September 2024.

1.20. As the Government had recently commenced a new Transfer of Care Delay Protocol, in March 2024 the Committee wrote to select organisations and the Minister for Health, to request their feedback on this protocol. Such correspondence is attached in Appendix C.

1.21. On 10 September 2024 the Committee Chair sought an extension of the new reporting date until 17 October 2024 which was granted. A subsequent extension was also sought on 15 October until 21 November which was also granted.

1.22. The minutes of the Committee are attached as Appendix B.

STRUCTURE OF THIS REPORT

1.23. This report consists of the following Chapters:

- Chapter 1 provides a brief overview of the Inquiry.
- Chapter 2 looks at the context and causes of transfer of care delays.
- Chapter 3 considers the effects of transfer of care delays.
- Chapter 4 considers the adequacy of data collection by the Tasmanian Government.

- Chapter 5 considers the State Government's response to transfer of care delays, and the efficacy of any such measures.

- Chapter 6 assesses the work of other jurisdictions to mitigate transfer of care delays and its associated impacts.

- Chapter 7 considers further short, medium and long-term actions to address the causes and effects of transfer of care delays.

2. CONTEXT AND CAUSES OF AMBULANCE RAMPING

2.1. This Chapter considers the context and causes of transfer of care delays.

2.2. From the evidence received, the Committee notes there are many factors that can contribute to transfer of care delays. These include hospital capacity and patient flow issues (access block and exit block), staffing issues, funding issues and gaps in primary and community care. The '9 to 5' Monday to Friday model of health care, balanced against the reality of the '24/7' model of emergency care, is also a contributor.

2.3. Mr John Bruning, Board Director and Vice-Chair, Australasian College of Paramedicine (ACP) described the various issues causing transfer of care delays during his opening statement to the Committee:

> ***Mr BRUNING*** *— … Our health system is no longer fit for purpose. It was really built for acute and emergency patient presentations. While we've continually added on and extended the health system to try to meet our changing needs, it simply isn't working. We have an ageing population with chronic and complex health conditions that require ongoing healthcare and management. We also have growing mental healthcare issues. Our tertiary hospital system is not designed to manage these patients effectively. We need to be managing the ongoing health of our community in the community.*
>
> *Transfer of care or ambulance ramping, access block, is a symptom of inpatient hospital services unable to meet patient demands, the inability to move acute patients from emergency departments to hospital wards, and the safe discharge and out-of-hospital care of patients. That leads into general access to primary healthcare, which sees people's conditions worsen to the point of calling triple-0 and needing a paramedic or transfer to hospital.*
>
> *Ultimately, ramping and access block highlights a health system in distress. The key issue is the inability for the community to access the right care in the right place at the right time. We are all aware of the issues in the primary healthcare system and the community access to it. I think we already know the solutions: appropriately resourced, equitably distributed, universally accessible and free primary healthcare would address many of the issues experienced by our ambulance services, emergency departments and hospitals.*
>
> *Before, non-life-threatening, non-urgent conditions were treated in the community, whether in a clinic, home or aged-care facility by a multidisciplinary team-based care. Most non-life-threatening but urgent conditions were treated in larger clinics and urgent care centres. That will actually have gone most of the way to resolving our healthcare issues.*[7]

2.4. Ms Emily Shepherd, Branch Secretary of the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch noted that transfer of care delay is caused by problems in the health system as a whole:

[7] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 1.

> ***Ms SHEPHERD*** *— … I guess the main point from the ANMF is that we can't look at transfer of care and ambulance ramping in isolation. Ambulance ramping and transfer of care delays are obviously a consequence of the broader, fundamental issue of access and flow challenges right across our hospitals and the health system. We are very concerned that there are moves afoot to see that there will be the mandatory offload of patients within 60 minutes in our emergency departments, . . . our view is that really is just transferring the risk of those patients from an ambulance stretcher into an overcrowded, over-capacity emergency department.*
>
> *What's more, whilst they are on the ramp, they are being cared for, as I alluded to before, by a health professional — albeit I appreciate that isn't the role of paramedics to be caring for patients in the emergency department on the ramp; they should be in the community responding to 000 calls. But putting a patient into an overcrowded, over-capacity emergency department is not the answer either.*[8]

2.5. This was echoed by Mr James Lloyd, also from the ANMF Tasmanian Branch who noted that the issues facing the ED are a symptom rather than a cause, and that failing to respond with a system-wide response will create further negative health outcomes:

> ***Mr LLOYD*** *— … Really, in the end, from my point of view, the core problem isn't in our hospitals. It is not the ambulance ramping or the emergency department overcrowding. It is really about the system as a whole. The ambulance ramping and overcrowding in the emergency department is really a symptom and not the cause, and the solutions we need to provide to alleviate overcrowding in ED and ramping have to take a whole system, a holistic approach, . . . transfer of care delays, is all about access into the system. But we also have to look at the other end, which is the discharge end. How are we going to get people out the other end? Plus, we need to look at the middle bit as well, which is about the beds and the capacity we have. We don't have enough capacity to get people out of the ED, to get people off the ramp.*[9]

2.6. The Minister for Health, the Honourable Guy Barnett MP, offered the following as to the causes of transfer of care delays:

> ***Mr BARNETT*** *— Transfer of care delays are a challenge, right across the nation's health system, and in Tasmania they're exacerbated, of course, by the ever-increasing demand on our ambulance service and our emergency departments, particularly driven by the lack of access to GPs and the bulk-billing crisis.*
>
> *Delays are further impacted by the bed block in our hospital system caused in part by the backlog of NDIS cases who cannot be discharged due to delays in care plans, along with the aged care patients waiting for placement in an already overcrowded aged care system.* [10]

2.7. Submission 37 from an Ambulance Tasmania (AT) paramedic, outlined the process of being ramped:

> *When we bring our patients to the RHH emergency department, if there aren't any available bed spaces/cubicles, and the patient is deemed too sick or inappropriate to be placed into the waiting room (which could be due to something as simple as poor mobility or someone who is unconscious due to being intoxicated with alcohol), the*

[8] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 2.
[9] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 3.
[10] Transcript of evidence, 8 February 2024, Minister for Health, p. 1.

patient will be "ramped" and kept in the care of the paramedics. We will then proceed to take our patient up to the old Emergency Medical Unit where there are approximately 11 bed spaces.

I would like to clarify here that this is an entire section of the emergency department which is not utilised by the hospital and instead serves to accommodate paramedics and their patients. Once we have taken our patients up to the ramp, we and our patient(s) are stuck there until the patient is eventually allocated a space within the ED. This could be 15 minutes, or it could be as long as 8 hours . . . During this time, the doctors in the emergency department will still initiate treatment of the patient even though they are technically still under our care (e.g organising x-rays, CT scans, administering certain medications, doing assessments etc). In fact, sometimes patients will be treated and subsequently discharged from the ramp without ever technically being in the emergency department.[11]

2.8. The Department of Health (DoH's) submission provided additional information about the triage process for patients arriving by ambulance to the ED:

Ambulance patients are triaged using the same criteria as walk-in patients and are treated equally in terms of wait time if triaged within the same category. For example, if an aged care resident is brought in by ambulance (as no other transport is available) and triaged as a category 4, higher triage category patients (1, 2, 3) that have arrived by ambulance or been brought to ED will be seen before the category 4 aged care patient. Just because a patient arrives by ambulance does not mean they receive the highest clinical priority in the ED. For example, a patient's condition may be clinically stabilised by treating paramedics, compared to a walk in patient whom has received no care or clinical assessment.[12]

2.9. The DoH submission also stated that patients experiencing transfer of care delays were able to be assessed and treated by ED clinical staff:

If the ED does not have capacity to assume care of a patient upon their arrival by ambulance, paramedics remain with the patient to support their clinical care until transfer of care can be completed. It is also important to note a transfer of care delay does not mean a patient's treatment is withheld where there is capacity to deliver this. ED assessment and treatment can, and often does, commence while a patient is awaiting transfer of care. For example, patients can be assessed and treated by ED clinical staff or be taken to have required diagnostic tests/scans while they are awaiting transfer of care.[13]

2.10. However, the Committee heard evidence that challenged the ability for a patient to be able to receive all necessary treatment, diagnostics and medication while on the ramp. Mr Ryan Posselt, a paramedic, outlined the limitations in the scope of care paramedics are able to provide their 'ramped' patients. He explained the dilemma paramedics often experience regarding the provision of treatment for their patients:

Mr POSSELT — *We have a dilemma. Do we risk our employment by allowing a patient to receive care that's not within our scope of practice – or do we let the patient suffer? What do we put first? Our own profession, our own career and the rules*

[11] Submission No. 37, Private witness, p. 1.
[12] Submission No. 64, Department of Health, p. 5.
[13] Submission No. 64, Department of Health, p. 5.

under which we work or the patient's need? In the cases of patients who have genuine life-threatening illnesses, paramedics are tending towards allowing the care to happen on the ramp that they technically shouldn't. We are all there for the same reason which is to make people better and to improve health outcomes, but the risk is that we lose our job.[14]

2.11. The Committee heard from multiple witnesses that limits to scope of practice, including the inability to provide suitable pain relief and timely diagnostic tests, do contribute to the quality of care for patients on the ramp. This was captured in comments Mr Cameron Johnson, a paramedic at a Committee hearing:

> ***CHAIR*** *— Is that something that never happened when you were a paramedic earlier in your career – there was never any pressure to work outside your scope of practice?*
>
> ***Mr JOHNSON —*** *This is a hospital ramping phenomenon. As paramedics, we are obliged to follow protocols or guidelines that we operate under, that is a long-standing situation. It was the same with the United States where we have protocols and the same in Ambulance Tasmania where we have had protocols. Now we have moved to guidelines, but because we are not medical doctors we have to operate within those guidelines. I guess it is for a patient safety mechanism, it is a way to ensure a degree of quality assurance with clinical practice. It is also a way to ensure best practice.*[15]

2.12. This limitation of a paramedic's scope of practice, their inability to provide to the required treatment and care for a 'ramped' patient, and the impact this on their mental health is discussed further in Chapter 3.

FINDINGS

The Committee finds:

1. Over the past decade the frequency and duration of ambulance ramping in Tasmania has dramatically increased.

2. Ambulance ramping is the result of whole of health system failures.

3. Ambulance ramping has itself caused and further exacerbated issues in the health system.

ACCESS BLOCK

2.13. Access block is one of the primary causes of transfer of care delays. Access block occurs when patients who have been assessed by the ED as needing to be admitted, are delayed from leaving the ED for more than eight hours due to a lack of staffed inpatient beds. This includes patients who were planned for admission but were discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or who died in the ED.[16]

[14] Transcript of evidence, 11 December 2023, Mr Ryan Posselt, p. 8.
[15] Transcript of evidence, 11 December 2023, Mr Cameron Johnson, p. 18.
[16] Submission No. 52, Australasian College of Emergency Medicine, p. 1-2.

2.14. The Department of Health (DoH) also outlined the various factors that impact transfer of care delays, noting the significant impact of access block:

> *Factors such as multiple simultaneous ambulance arrivals, high ED patient acuity, and ambulance patients competing with 'walk in' patients can contribute to transfer of care delays. However, transfer of care delays mostly occur as a result of ED bed capacity being compromised due to high numbers of inpatients in the ED awaiting access to an inpatient bed elsewhere in the hospital. As such, transfer of care delays are a symptom of access block within public hospitals.*
>
> *The Australasian College of Emergency Medicine defines access block as "the situation where patients who have been assessed in the ED and require admission to a hospital bed are delayed from leaving the ED for more than eight hours due to a lack of inpatient bed capacity."*[17]

2.15. The Australasian College of Emergency Medicine (ACEM) highlighted the prevalence of access block in Tasmanian hospitals:

> *ACEM undertook two access block snapshot surveys across Australian EDs in 2019 (June and September) and presented them to the Health Minister at the time. Across both surveys, ED patients at [the] Royal Hobart Hospital (RHH) and Launceston General Hospital (LGH) accounted for 29 percent of those identified as access blocked at Australian hospitals. This was despite patients in these EDs making up less than 2 percent of all ED patients at the time of the survey, representing the worst access block in Australia.*[18]*.*
>
> *Almost five years later, the situation has not improved, with wait times blowing out to levels previously never imagined possible. In 2021-22, it took over 22 hours for most (90 percent) of admitted patients to depart Tasmanian EDs (in comparison, the national average was just over 15 hours).*[19] [20]

2.16. Ms Jess Brennan, a former nurse at the Launceston General Hospital (LGH), also noted the access block in that hospital is particularly acute:

> *As I am sure you are aware there was recently a published report that out of 300 Australian hospitals, the LGH Emergency Department (ED) has the worst bed block of any hospital. We see patients on a daily basis waiting horrendous amounts of hours and days in the ED as admitted patients, waiting a bed upstairs on the wards. For example, I personally had a family member admitted on the weekend who was in the ED for 52 hours before they were transferred to a medical ward. I have seen patients waiting up to 100 hours for a bed, and unfortunately this is not an uncommon occurrence.*
>
> *This has a significant burden on ambulance ramping, as there is just simply nowhere for patients to go. Ambulances are therefore forced to be ramped for hours on end, putting our community at risk with no ambulances on the road to simply do their job. From what I understand, the LGH has the largest catchment area in the state, yet we have a significantly smaller hospital than the RHH. The opening of [Ward] 3D did*

[17] Submission No. 64, Department of Health, p. 3.

[18] Australasian College for Emergency Medicine, 2022. Tasmania's emergency doctors: healthcare staff are breaking. Media release published on 30 December 2022, referenced in Submission 52, footnote 14.

19 Australasian College for Emergency Medicine, 2019. Access block in Tasmanian EDs: Findings from the 2019 Access Block Snapshot Survey, referenced in Submission 52, footnote 15.

[20] Submission No. 52, Australasian College of Emergency Medicine, p. 3.

relieve some pressure for a short period of time, but unfortunately with Tasmania's ageing population, our hospital is constantly full with unwell, elderly, co-morbid patients with nowhere to go. I believe addressing bed block would improve ambulance ramping at the LGH, and I would not be surprised if this was the case at the RHH as well.[21]

2.17. Dr Paul Scott, Acting Emergency Director of the Royal Hobart Hospital (RHH) Emergency Department, commented about the situation at his hospital:

… Essentially, we are trying to sort people, ideally in a well-functioning system, within four hours and then having them go to the ward. The national KPIs have 60 percent of patients off to the ward within four hours and 90 percent within eight hours. We sit at about 10 percent within four hours for patients requiring admission to hospital and around 40 odd percent for eight hours. If you look at how long it takes us to get 90 percent of patients requiring admission to the main part of the hospital, instead of 90 percent within eight hours which is the national target, it takes us 25.5 hours.[22]

2.18. In his submission, Dr Scott, also noted a lack of subacute beds both in district hospitals and aged care facilities, to be one of the causes of access block:

A main contributor of access block in Tasmania includes the lack of subacute care beds which are both state (district hospitals) and federally (residential aged care facilities) funded. With the mean age in Tasmania growing, increasing at an accelerated rate, the lack of access to residential aged care facilities will continue to increase the burden of access block and in turn, ToCDs [transfer of care delays]. ACEM has a position statement on access block that highlights the 'whole of hospital' and 'whole of system' approach required.[23]

2.19. Ms Kylie Stubbs from the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch deemed access block to be considerably impacted by the demands of elective surgeries:

***Ms STUBBS** – . . . I'm a registered nurse and work in the operating room suite at the Launceston General Hospital. My view on what contributes to access block is elective surgery and elective surgery targets. On any given day, if we have 30 to 40 elective surgery cases that we need to do and that's prioritised, that prevents patients getting out of ED into beds. We also have bottlenecks that occur in our recovery room because we can't get patients out to their respective wards.*

On any given day, the time that we spend waiting to get our patients out of recovery can vary, and on one day in particular, in a 14-hour period of operating we spent 25 hours just waiting for wards to come and get patients. That can be because they're understaffed, they're doing double shifts; it can also be that we're just at capacity, we just can't move patients. Then those patients who are stuck in ED because of those factors are, as we know, dying while being ramped.[24]

2.20. Dr Juan Carlos Ascencio-Lane, ACEM, commented that increasing presentations to the ED are impacting patients' access to a hospital ward bed:

[21] Submission No. 15, Ms Jess Brennan, p. 1.
[22] Transcript of evidence, 23 January 2024, Dr Paul Scott, pp. 4-5
[23] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 2.
[24] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 15.

> ***Dr ASCENCIO-LANE*** *– We have seen some amazing initiatives being put out by this Government and previous governments . . . 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.*[25]

2.21. Dr Ascencio-Lane also noted that, despite initiatives from multiple governments, Tasmanian hospital capacity has not increased in line with the demand driven by our ageing population and increase in chronic diseases:

> ***Dr ASCENCIO-LANE*** *… The number of presentations has rapidly increased. We have seen over a period time the number of patients needing admission increasing by 63 percent, whereas the number of beds has only increased by about 30 percent 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.*[26]

2.22. Access block and transfer of care delay is sometimes attributed to low acuity patients 'crowding' the ED instead of being treated elsewhere, such as by General Practitioners (GPs). DoH commented that:

> *Many patients who cannot access adequate primary care find themselves forgoing necessary care (resulting in worsening of health conditions) or presenting to other health care settings, such as the ED. In 2021-22, Tasmanian public hospitals had 58 274 GP-type presentations to their EDs,*[27] *equating to around 33.6 percent of total public hospital ED presentations (173 276 for 2021-22).*[28] *This increases burden on public hospitals by contributing to ED overcrowding.*[29]

2.23. Dr Ascencio-Lane argued access block is not caused by patients presenting to EDs that could seek care elsewhere, but by those who really need hospital treatment:

> ***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?*

[25] Transcript of evidence, 24 January 2024, Australasian College of Emergency Medicine, p. 3.
[26] Transcript of evidence, 24 January 2024, Australasian College of Emergency Medicine, p. 3.
[27] Submission No. 64, Department of Health, p. 9, footnote 14.
[28] Submission No. 64, Department of Health, p. 9, footnote 15.
[29] Submission No. 64, Department of Health, p. 9.

Dr ASCENCIO-LANE *— My view overall, 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 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.[30]

2.24. This was echoed in the Rural Doctors Association Tasmania (RDAT) submission and in verbal evidence given by Dr Ben Dodds, RDAT President:

CHAIR *– . . . you say [in your submission] that the narrative produced by the state Government quite regularly, and also by the Commonwealth Government, is the ramping problem is caused by a failure in primary health delivery in the community and by the failure of GPs being there for people when they are needed. But you have separated the issue of people who turn up in emergency departments who need some primary health care and are very unwell, [from those who] need a bed. Do you want to speak to that?*

Dr DODDS — *I think it's a really important issue and it's the rhetoric that we hear. For example, four out of ten patients presenting to an emergency department don't require emergency care. There are a few studies that have actually examined the way the federal government defines that, and have decided that, actually, of those patients that presented, a lot of them received a form of care in the emergency department that is not currently available in general practice. I've outlined a few of those in the submission.*

There should be a very clear delineation that if a patient arrives or selects an emergency department for a non-acute issue that could have been managed better in primary care, they will not contribute to ramping or to access block, because they are not causing an ambulance to delay its offload, they are not using an emergency department bed, and they are not waiting for an acute inpatient bed. So that's that issue.

2.25. Dr Scott, of the RHH ED, also acknowledged that access block is not caused by patients who could be seen elsewhere but by those patients who do need to be admitted to hospital:

[30] Transcript of evidence, 24 January 2024, Australasian College of Emergency Medicine, p. 4.

CHAIR *— The minister has said that 40 percent of emergency department attendees are non-urgent and people who should be seeing a GP. . . . the idea is proposed that urgent care centres will be an amelioration of the current situation. From the data you have just provided, do you think that there is a relationship between the urgent care centres and more community care, and the 20 000 patients per year that need to have a bed in an inpatient ward?*

Dr SCOTT *— There are multiple layers to that question. Firstly, GPs do an absolutely amazing job and if we are to look at the very long-term health strategy for keeping people out of emergency, it is primary care. It is disease prevention, good health education, better health literacy; absolutely important there. There is a lack of resourcing of GPs in the community.*

When we look at the data on patients who [access EDs] . . . have injuries, illnesses or medical requirements that could be handled solely by a specialist GP in the community, the numbers are extremely small. When I have looked at it, it is less than five patients per day out of 210. These types of patients are managed at national KPIs. They are seen within time, they are discharged within time. These are not the patients who contribute to access block. The people contributing to access block are the patient's needing admission into hospital.

Moving on to urgent care centres, they absolutely provide an important role for the community, but I see them as an alternate to accessing a GP-type service. [Urgent care centres] do not address access block, as the patients who require admission to hospital… who cause access block. They address the patients who have relatively minor illnesses and injuries who could be sorted well in the community and followed up in the community.[31]

2.26. Dr Dodds, of RDAT, did however recognise that lack of access to adequate GP and community care in a timely manner, leads to an exacerbation of patients' health conditions. As a result, more people seek an ambulance response that could have been prevented, and are more unwell when seeking an ambulance response and emergency hospital care:

Dr DODDS -- *… if patients are unable to see their regular general practitioner — or at least their general practice at which their information is contained and they're known to the staff – they are likely to unfortunately experience exacerbations of their chronic disease and they can go unnoticed for several days to weeks, to the point where they become so unwell that they do require an ambulance, they do require an acute emergency department bed, and they are then admitted to hospital.*[32]

2.27. Access block can have a significant impact on patients, with evidence received that patients experiencing access block are at risk of increased adverse outcomes:

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? …*

[31] Transcript of evidence, 23 January 2024, Dr Paul Scott, p. 6.
[32] Transcript of evidence, 8 November 2023, Rural Doctors Association Tasmania, p. 10.

Dr ASCENCIO-LANE *— From the statistics alone, we know that if 10 percent 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 percent 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.[33]

*****This was referenced in ACEM's submission (Jones, P.G. and van der Werf, B. 2021, "Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand". Emergency Medicine Australasia, 33: 655-664.).[34]

FINDINGS

The Committee finds:

4. The major direct cause of transfer of care delays is access block.

5. Tasmanian hospitals are experiencing increasingly high levels of access block.

6. The observed increase in patients with low acuity accessing Emergency Departments, who do not need a hospital bed, does not significantly contribute to access block and as a result does not influence transfer of care delays.

7. Given limits to hospital resources, competition can occur for bed access between Emergency Department patients and patients awaiting scheduled surgery, aggravating access block and elective surgery waitlists.

HOSPITAL CAPACITY AND PATIENT FLOW

2.28. With increasing demand for public hospital services, there has been an increase in ED attendances. This increase in attendance leads to high hospital occupancy rates and hospitals running without any surge capacity.

2.29. Mr David Pittaway, an Associate Nurse Unit Manager and ED Navigator at the Royal Hobart Hospital (RHH) for many years, noted there has been an increase in the capacity at which hospitals regularly operate:

[33] Transcript of evidence, 24 January 2024, Australasian College of Emergency Medicine, p. 4.
[34] Submission No. 52, Australasian College of Emergency Medicine, p. 2.

I am of the understanding that Australian hospitals used to be run at 80% capacity. When I reflect on my student nursing days on public medical wards in the 1980s, they weren't as busy as my ward colleagues report these days, and I often lea[r]ned of hospital-based student nurses being sent home for a few hours and complete their shift later that evening, a practice known as 'split shifts' … their work wasn't needed all day, only some of it. The hospitals were not, or ever, full.

Now, for reasons I can only speculate on, hospitals are now run at 100% capacity, so there is no surge capacity. Staff are always busy, patients do not get the quality nursing care they used to get, management is constantly putting staff under pressure, all which goes to making the work less satisfying and attractive as a long-term prospect.[35]

2.30. Mr Pittaway was asked to elaborate further on the impacts of hospitals operating at full capacity in verbal evidence to the Committee:

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

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

We have a hospital that is at 100 percent capacity and has no slack. From my position at the navigator's desk, I can see what is happening in the rest of the THS. I can see that, you know, Launceston is on 'level four' and Burnie is on 'level three' and Mersey is on 'level one or two' or whatever. We can see that this is happening all around the state. To me, it is industrial healthcare. It's push in one end, push out the other end. If that is what people want their health system to be, so be it, but you will not be having many staff staying.[36]

2.31. Mr Hamish Bourne, Policy Lead from the Australasian College for Emergency Medicine (ACEM), explained the value of National Emergency Access Targets for hospitals to assist patient flow:

***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.*

[35] Submission No. 46, Mr David Pittaway, p. 6.
[36] Transcript of evidence, 9 November 2023, Mr David Pittaway, p. 10.

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.

ACEM decided to go back to the drawing board and have a look at hospital access targets, recognising 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 demands . . .

. . . 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 generate patient flow, because we know that there is no one solution for patient flow, there will be things that vary from health service to health service.[37]

2.32. The Department of Health (DoH) submission notes it has implemented a *Statewide Access and Patient Flow Program* designed to improve patient and access flow in the Tasmanian Health system:

… transfer of care delays are a symptom of wider health system challenges that result in access block. To respond to these challenges DoH has redeveloped a Statewide Access and Patient Flow Program to deliver a system-wide framework for improving patient access to, and flow through, the Tasmanian health system. The Program aims to improve whole-of-system processes which can affect transfer of care delays, such as flow through EDs, patient admission and discharge processes, and patient access to ongoing care in appropriate settings when acute hospital care is no longer needed.

Improving access and patient flow across Tasmania's health system is also a strategic priority under the Service Plan, which include specific KPIs regarding access and flow.[38]

FINDINGS

The Committee finds:

8. Insufficient hospital bed capacity is a fundamental problem that contributes to access block.

9. The major Tasmanian hospitals have been running, for years, close to or above capacity, resulting in them operating without surge capacity.

10. Over-capacity hospitals are the result of hospital attendances and admissions increasing faster than bed numbers, further influenced by the availability of staff to service beds, and the ability to discharge patients in a timely manner.

11. Hospitals continually operating close to, at, or above capacity negatively impacts staff training and teaching, and reduces the ability for staff to provide quality, holistic care to patients.

[37] Transcript of evidence, 24 January 2024, Australasian College of Emergency Medicine, pp. 5-6.
[38] Submission No. 64, Department of Health, p. 25.

12. The Tasmanian Health Service *Statewide Access and Patient Flow Program* currently lacks hospital emergency tracking targets and performance indicators, as well as commensurate funding.

EXIT BLOCK

2.33. Exit block is where hospital patients are ready to be discharged but do not have an appropriate destination to go to or support services available. This is often the case with patients who are awaiting aged care or disability care, needing in-home supports, or access to suitable housing.

2.34. The effect of exit block is fewer inpatient ward beds are available for patients to be transferred from the ED. This in turn leads to increased ramping times, longer waiting times for ambulances in the community, increased length of stay for patients in the ED, and delays in elective surgeries. Exit block can also increase health care costs and the likelihood of hospital-acquired complications for patients who stay in hospital longer than medically necessary.

2.35. A major cause of exit block is the inability for hospitals to discharge patients waiting to enter aged care or those awaiting the completion of National Disability Insurance Scheme (NDIS) assessments. Department of Health (DoH) noted:

> *Keeping older people and people with disability who are medically ready for discharge in hospital is not best for the individual, and places significant capacity and cost pressures on the public health system.*
>
> *Aged care and NDIS related discharge delays and the impacts of these on ED and inpatient public hospital capacity, are key areas of concern across states. The Commonwealth is responsible for planning, funding, policy, management, and delivery of the national aged care system, and for regulating the provision of services under the NDIS. Policy and funding changes, as well as service shortages, in these care systems can have major flow-on impacts to the public health system. Public hospitals become providers of last resort, which in turn contributes to transfer of care delays, as hospital beds are "blocked" caring for people who could be more appropriately cared for in the community. The Commonwealth has been engaging more closely with states on these issues recently, and it is vital this engagement continues and is further strengthened to improve integration and system interfaces.*[39]

2.36. Primary Health Tasmania also corroborated this, noting discharge delays were impacting the capacity of available hospital beds:

> *Reduced inpatient bed capacity due to discharge delays (also known as bed block) for complex patients remains a key issue in Tasmania and results in reduced bed capacity for patients presenting to emergency departments who need to be admitted to hospital.*
>
> *The two primary factors contributing to bed block in Tasmania have been reported (Jeremy Rockliff, 2022) as:*

[39] Submission No. 64, Department of Health, p. 10.

• Delays in finding appropriate medical support (e.g., a GP) for transition of care for residents of aged care facilities who are medically ready to be discharged from hospital.

• Delays processing National Disability Insurance Scheme supports for patients with a disability to facilitate post discharge transition planning.[40]

2.37. DoH presented information about the dramatic increase in time taken to transfer aged care patients form Tasmanian hospitals to appropriate residential or in home care and the impact this has on exit block:

Between May 2023 and September 2023, calculated on a fortnightly basis, the average number of aged care patients medically ready for discharge in Tasmania's four major public hospitals was 42.3. While in some cases these patients may be in subacute beds within the state health system, this still means that the subacute bed is "blocked", and another patient remains in an acute bed as they cannot access that subacute bed. This bed block has flow on impacts for EDs as they care for patients waiting for acute care beds, limiting capacity to take in more patients, and therefore contributing to transfer of care delays.

Report on Government Services 2023 data indicates there can be extensive delays in the transfer of aged care patients in Tasmanian hospitals into more appropriate care settings, including residential or home care. For example:

• in 2021-22, wait times for Level 4 Home Care Packages in Tasmania (while improved from previous years) were the longest of any state at seven months,[41]

• in 2020-21, the proportion of patients whose length of time in hospital between completion of treatment and entry into residential aged care was greater than 35 days was 13.5 percent, above the national average of 9.8 percent,[42] *and*

• the total number of hospital separations for older people with a length of stay of 35 days or more increased in 2020-21 to 61 separations, up from 41 separations in 2019-20.[43] [44]

2.38. Issues were also raised around the way aged care homes operate. The Australian Nursing and Midwifery Federation (ANMF) noted aged care homes have little option but to send residents to hospital to receive the full range of care they need, and the state has little ability to influence this situation:

In addition, the State and Federal funding arrangement poses difficulty due to the exclusion of primary care and aged care. These sectors have a significant impact on the transfer of care delays. For example, aged care residents are often transferred to the ED as some aged care providers only staff to the absolute minimum and there is no staffing contingency if a resident becomes unwell and needs high acuity care. These residents are transferred to the acute facilities. The difficulty this represents is that the State have no jurisdiction over how funding is allocated in the aged care space and therefore limited ability to resolve these issues, or even seek funding for the care

[40] Submission No. 55, Primary Health Tasmania, pp. 5-6.
[41] Table 14A.23, Aged Care Services, Report on Government Services 2023, Submission No. 64, Department of Health, p.10, footnote 16.
[42] Table 14A.32, Aged Care Services, Report on Government Services 2023. Submission No. 64, Department of Health, p.11, footnote 17.
[43] Table 14A.32, Aged Care Services, Report on Government Services 2023. Submission No. 64, Department of Health, p.11, footnote 18.
[44] Submission No. 64, Department of Health, pp. 10-11.

provided for these patients in acute facilities from either the provider or the Federal Government.[45]

2.39. The Committee also heard that the model of care in residential aged care facilities does not provide the comprehensive medical care patients need on site. Dr Frank Formby, a palliative care medical specialist, noted:

*RACFs [*Residential Aged Care Facilities*] do not appear to have any obligation to ensure a timely medical assessment in the facility whenever one of their residents becomes acutely unwell. When the resident's allocated general practitioner, assuming there is one, is unavailable there is no back up. The default is to send the resident to the Emergency Department, even if it is contrary to the patient's Advanced Care Plan, their wishes or the wishes of their families. In any case, RACFs remain inadequately staffed to cater to the increased needs of their residents, when they become more unwell. Only registered nurses can administer controlled drugs and new medications, to treat acute illnesses. Where electronic prescribing is used in the RACF, locum GPs, geriatricians and palliative medicine specialists who visit, are unable to prescribe new medications because they cannot sign into the system. This means that the patient is either sent to hospital immediately or they get worse because they do not receive the medications they need and then go into hospital.*[46]

2.40. This issue was also discussed in public hearings with a number of witnesses. Mr John Bruning from Australasian College of Paramedicine (ACP) said the following:

***CHAIR** — … in your view, according to the research, 13 to 40 percent of all transfers from home care facilities to the emergency department could be avoidable by providing clinical care within those facilities. That is a huge statistic given the increase in older people who are coming to emergency for the very reasons that you have been talking about. What has the response been from the Government?*

***Mr BRUNING** — … We know that even when we have nurses in aged care facilities, we are still having ambulances and paramedics attend and transfer patients and because it is felt that it's not safe to leave them in the facility and they end up having to be taken to the emergency department. This is a case where that person probably does not need the facilities at the hospital, but they need ongoing care which has gone above and beyond what is currently available to them.*

Our recommendation is not just paramedics but team-based care, a multi-disciplinary team of paramedics, nurses, GPs, doctors who are able to work together and provide care, either in the home or in the aged care facility and means that they do not go to hospital except when they need the facilities that the hospital provides. …

We have been talking federally to the Government about the role paramedics can play in supporting discharge of patients and the care of patients in aged care facilities. We run into that hole between state and federal as to who really wants to make this work as effectively as possible because it benefits both sides, but it might be seen that it helps the hospital more therefore it is not as big a concern. It is definitely what is going on with the care our community needs that this is a big factor.

[45] Submission No. 36, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 4.
[46] Submission No. 74, Dr Frank Formby, p 2.

Can we stop people going in and can we help them come back out? If we can get that right, we would address a lot of our challenges.[47]

2.41. Exit block is influenced in part by the fact that EDs run 24 hours a day, 7 days a week, but most specialist consultants only work Mondays to Fridays. This issue was expanded on by Dr Scott, Acting Director, RHH, in public hearings:

> ***Ms DOW*** *— … I wanted to ask you about a cultural change to a seven-day-a-week health system. This has been mentioned a number of times during our committee proceedings and the importance of having access to radiology, pathology, and pharmacy 24 hours a day. . . How would it improve the flow of the hospital and the ability to get patients back out, discharged into the community?*
>
> ***Dr SCOTT*** *— Since writing this submission, there's been some excellent work in the medical leadership space at the Royal Hobart Hospital and they have actually proposed a seven-day-a-week medical admissions team that would be based in the emergency department. They fully recognise the Royal Hobart is now big enough to no longer be a Monday to Friday model, 8.00-5.00. It is now a hospital that requires a 24-hour level of service.*
>
> *Just as the medical workforce is strained in terms of finding people willing to work for less money and worse conditions, that is true right across the board, from pharmacy to allied health, radiographers, pathology staff, other allied Health staff, clerical staff, support staff. There is a lack of resourcing, generally, to be able to run services 24 hours a day.*
>
> *So, what would be regarded as a routine care episode for a patient, such as getting an ultrasound for perhaps a pathology that you want to protect them from doing a CT on – perhaps a young lady who is pregnant – that is not easily available; you have to call people in from home. That may impact the next day's roster and is certainly not available after hours in any reliable way.*
>
> *Yet we have people turning up throughout the day, every day, seven days a week, more so on public holidays and long holiday periods. There is a mismatch in availability of resources and staffing to support a seven-day-a-week function.*[48]

2.42. Dr Formby, in his submission, noted a lack of urgency in hospital processes to facilitate the timely discharge of patients:

> *My experience in many hospitals is that there is a lack of urgency in discharging patients. They are waiting for scans that could be done after they leave hospital, or they are kept under observation or to fine tune their treatment, when they are well enough to go home. The discharge destination and how discharge can be achieved should be considered on the first day of admission to hospital and be front of mind throughout the hospital stay. When medical follow up is required, GPs should receive an incentive to review patients at the appropriate time, as determined by the hospital team.*[49]

[47] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, pp. 6-7.
[48] Transcript of evidence, 23 January 2024, Dr Paul Scott, p. 8.
[49] Submission No. 74, Dr Frank Formby, pp. 1-2.

FINDINGS

The Committee finds:

13. The inability to discharge patients in a timely way ('exit block') exacerbates access block by reducing the number of available hospital beds, and impacts on other hospital functions.

14. Exit block is primarily caused by delays in finding appropriate care for patients outside of hospitals. Blockages occur in identifying appropriately equipped residential aged care, disability care, in-home supports and housing.

15. The admission process does not include adequate discharge planning with the patients, their family/guardians, or hospital staff, which often contributes to exit block.

16. Aged care homes sometimes have beds that become available but are not used to discharge hospital patients into because there is no system to alert hospital staff.

17. The model of care in aged care facilities does not always provide the comprehensive medical care that patients need on site, which is a factor that delays patient discharge.

18. Limited operating hours for specialists, pharmacy, diagnostics, allied health and other key hospital services, contributes to delays in the timely discharge of patients.

19. Patients awaiting hospital-dispensed medications can lead to long waits for discharge.

STAFFING SHORTAGES

2.43. The Committee heard that serious understaffing has lengthened the time patients are spending on the ambulance ramp. Submission 37 spoke of understaffing in Ambulance Tasmania (AT):

> *Ramping prevents ambulances from responding to people in the community when there already isn't enough ambulances to meet the demands of the public. Here are some pretty damning statistics to help contextualise the seriousness of this point:*
>
> - *The population of Hobart and its surrounding suburbs is approximately 250,000*
> - *On a night shift, assuming we are fully crewed, there will be 9 full paramedic crews available to respond in the greater Hobart area. Therefore, on a night shift (assuming we are fully staffed), this equates to 1 paramedic crew per 27,000 people.*
>
> *However, we are very rarely fully staffed. This is largely due to staff fatigue/burnout, but once one or two people call in sick it causes a snowball effect whereby more people will call in sick as nobody wants to come to work when we are short-staffed.*

Therefore, it is not uncommon for us to be missing 2-3 crews on a night shift, and the ratio could be as high as 1 paramedic crew to 35,000-40,000 people. On one of my most recent night shifts we were down 2 crews and the region was extremely busy, as was the emergency department.

Throughout the whole night every crew was either on a job, or they were ramped, and there was constantly around 10 ambulance jobs waiting at any given time. Now, imagine on a night like this, if you or somebody you loved had a medical emergency. Imagine calling 000 to request an ambulance and being informed that there was none available, and they weren't sure how long it would be until they could dispatch one to you.[50]

2.44. Staff shortages in AT were also mentioned by former Launceston General Hospital (LGH) nurse Ms Jess Brennan:

Having just completed 2 months of night shifts myself, on many of those shifts Ambulance Tasmania (AT) was significantly short staffed. This led to them having to split crews and have single officer responders on the road, often leaving one or two Paramedics at the LGH looking after up to 5 ramped patients. This is such an unsafe working environment and I honestly feel for the paramedics who are put under immense pressure on a daily basis.[51]

2.45. Mr David Pittaway, a registered nurse and ED Navigator at the Royal Hobart Hospital (RHH), wrote about how understaffing of inpatient ward beds slows the movement of patients out of the ED:

The two most common reasons for no available beds are that the ward is full, or, that they are understaffed and cannot open all their beds (according to the agreed nurse-to-patient staffing ratios).
Reasons for under-staffing that the [ED] Navigator hears are:
- sickness or other leave;

- high acuity patients (near ICU level care) already on the ward that require more than the anticipated number of nurses to care for them;

- patients who require near constant (not ICU level) care/observation due to multiple co-morbidities;

- patients with confusion, due to many different causes, who require more than anticipated observation and interventions, when Patient Safety Observers are not available.

- the need to keep a bed or two spare for 'expected unexpected' events, such as STEMI (heart attack) beds on the Cardiology ward, or emergency post-operative beds on surgical wards.

Another reason given for refusing to take a patient with complex or specialist care is that there are no accredited/skilled staff on shift to care for the patient in question. Or, there are simply no empty staffed beds available in the hospital.[52]

[50] Submission No. 37, Private witness, p. 4.
[51] Submission No. 15, Ms Jess Brennan, p. 1.
[52] Submission No. 46, Mr David Pittaway, pp. 4-5

2.46. Ms Emily Shepherd from the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch spoke to the Committee in relation to the need for increases in nursing staff:

> ***CHAIR*** *— I remember . . . the access bed block round table, a big event Michael Ferguson organised when he was minister . . . Do you want to tell the Committee what's happened in terms of getting the staffing increases that are needed, that were recognised at that point?*
>
> ***Ms SHEPHERD*** *— I think the staffing situation is worse than it was at that time, which I think was around 2017/2018. Obviously, we foreshadowed at that time that the research from 2014 that indicated we've got an ageing population and ageing workforce where we're going to see significant losses of nurses and midwives across the country and internationally. We foreshadowed that in 2018 . . . we then encountered COVID-19 in 2020, which exacerbated the shortfall in nurses and midwives. Unfortunately we're now seeing multiple vacancies. . . we're now very much reliant on our graduate nurses coming through as our pipeline of more nurses, potentially more midwives as well, but they need additional supports.*[53]

2.47. Private Witness 5 wrote of the staffing problems they had experienced and the need to have comparable pay to other states to retain staff in the Tasmanian Health Service (THS):

> *Staffing…. now here is a big problem that is not being addressed. Nurses' wages are not on pay parity to the mainland, yet we do more with less. The excuse that the cost of living in Tasmania is cheaper is no longer valid. The government is paying astronomical amounts of money for double shifts and agency. Here is a new concept, pay them what they are worth. A tradesmen gets paid more than a nurse! We are only responsible for the wellbeing of another, and perhaps save a life or two!*[54]

2.48. Tim Sloane, a registered nurse, also spoke of the lean staffing models in hospitals:

> *The current staffing models are too lean to provide consistent quality nursing care, and the recruitment incentives are not competitive enough in regard to mainland incentives. We need to recruit and maintain staff, be receptive and flexible to their need to have them committed to our communities. Decrease agency staff slowly as we build our permanent staff.*[55]

2.49. Shortages in the availability of cleaning staff to clean beds between patients was also discussed as another reason for bed block. Ms Shepherd and Ms Kylie Stubbs of the ANMF Tasmanian Branch spoke of these delays:

> ***Ms SHEPHERD*** *— . . . there are sometimes delays in transfers of patients out of ED into ward unit beds because of the lack of support staff. There might be an instance where there needs to be a terminal clean, for instance, over that particular bed space, and often there just is not the support staff to come and do that, and often relying on nurses and midwifes to clean beds to get patients -*

[53] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 11.
[54] Submission No. 5, Private witness, p.1
[55] Submission No. 6, Mr Tim Sloane, p. 1.

CHAIR *— Cleaning staff, in that instance.*

Ms SHEPHERD *— Yes, exactly.*

CHAIR *— Do the cleaning staff work overnight?*

Ms SHEPHERD *— There's a lack of . . . shared roles across multiple wards and units, but certainly even just after hours . . . We called for additional funding to support the ongoing support roles, which included those ward clerks, ward aides and cleaners to be able to support and facilitate the appropriate infection control procedures, but also to aid in access and flow, particularly just in terms of answering the phone after hours — the phone is ringing off the hook, and people not being able to communicate because of locked wards and units and not having the appropriate numbers of support staff.*

Those support staff are really critical in terms of aiding that access and flow, and when a bed does become available, ensuring a sufficient number of support staff to be able to clean it immediately, or commence a terminal clean, so it's not a further delay.

Ms STUBBS *— On that point — that process of a terminal clean can take three hours, so that's three hours where you've got someone cleaning a room and you can't get a patient into that bed, and that's a common problem.*[56]

2.50. This issue was also raised by Mr Pittaway who noted there were often problems not with having an empty bed available, but in there being a delay having it cleaned and ready for a new patient:

> [speaking of an allocated bed not being ready] … *[the] ward is waiting for the bed and room to be terminally cleaned. This is a common reason for delay. When I ask when the clean might be done by, I have often been told NOT FOR SOME HOURS. A terminal clean is the comprehensive cleaning process required after an infectious patient leaves that room e.g. a COVID or other respiratory virus-laden patient; someone colonised with MRSA, VRE, C diff or some other medication-resistant microbe. Every surface other than the ceiling requires cleaning, as do all items in the room; furniture, fittings, handles etc. This is obviously a time consuming process, and, it requires attention to detail so transmission of the organism does not occur to the next room occupant. The constant need for te[r]minal cleaning will be an ongoing issue into the future.*[57]

[56] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 14.
[57] Submission No. 46, Mr David Pittaway, p. 4.

FINDINGS

The Committee finds:

20. Staffing shortages are a major factor that contribute to transfer of care delays.

21. Understaffing, especially in nursing and allied health, negatively impacts on patient care, leading to longer hospital stays for patients and a reduction in bed availability.

22. Tasmanian hospitals and Ambulance Tasmania would benefit from more permanent staffing contracts.

23. Many staff are leaving the Tasmanian Health Service for other states or private providers due to a lack of parity for pay and conditions.

24. There is a shortage in available cleaning staff to prepare vacant beds to ensure the efficient transfer of patients to wards from the Emergency Department.

RESOURCING

2.51. Several submissions discussed a lack of funding in the healthcare system as a cause of transfer of care delays. Private witness 18 noted:

> *Ramping comes down to a massively under-funded health system. We all know that. Our underfunded hospital beds and staff are reduced to critical levels, and as the effects ricochet down the ward system to emergency departments, we ambulance officers are left hanging around corridors with extremely unwell patients, while our community needs us an hour away.*[58]

2.52. Other submissions noted that transfer of care delays create additional resourcing costs. Submission 37 noted:

> *Ramping is a gross misuse of Government money. Not only do paramedics cost more to employ than nurses, but in the last couple of years Ambulance Tasmania have also introduced a new model whereby staff can work on the ramp on overtime in an attempt to ameliorate the stress on the service. This means paramedics can work on the ramp and get paid 1.5x their substantive wage (approximately $80 an hour for a year 1 paramedic or around $120 an hour for managers). Therefore, an 8 hour shift on the ramp would see a manager earn nearly $1000 in overtime wages.*
>
> *This has, admittedly, been a relatively effective temporary solution to ramping, but is a fundamentally flawed concept and incurs a considerable financial burden on what is an already underfunded and under-resourced service.*
>
> *As an alternative to the current ramping model, the hospital could simply employ a few additional nurses in the ED specifically to look after ramped patients. This would not only be a more cost-effective solution but, for reasons I've already mentioned, would significantly improve Ambulance Tasmania's capacity to respond to patients in*

[58] Submission No. 18, Private witness, p. 2.

the community, and also improve the level of care provided to ramped patients as nurses are specifically trained to look after patients in a hospital setting, unlike us.[59]

2.53. Dr Paul Scott from the Royal Hobart Hospital (RHH) in his submission commented that the use of locum doctors in hospitals was a major cost on the health care system. In hearings, the Chair questioned Dr Scott further about the use of locums:

> ***Dr SCOTT*** *— I have a large number of doctors on the book. Very few of them work fulltime. I have gaps in my rostering because of other places around Australia being more attractive to work for a variety of reasons. Consequently, to deliver the care to the public, I need to get doctors to treat the patients. This year, particularly and at the back of COVID-19, we've had to use locums extensively. We've had some very aggressive recruitment campaigns and commitment from the Tasmanian Health Service in terms of funding to increase our permanent staff numbers.*
>
> *I am happy to say for the first time since I took on the role, we're looking much better from the permanent staff perspective from around March — April this year up to our full establishment of registrar doctors. We're still under from a staff specialist perspective.*
>
> *Taking you back to the previous statement of the increased supervisory burden, the registrars that I have, whilst I am full on my establishment, are generally much more junior than they were four or five years ago. I now have the problem of not having enough doctors who are senior enough to maintain the department at night. Now, I also have the burden that the remaining consultants have increased supervisory risk and burden. You often have a queue of eight or ten people lining up to talk to the specialist to check patient care, to make sure patients are safe. That can go on for hours and hours.*[60]

2.54. Ms Emily Shepherd from the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch spoke to the Committee in relation to the need for nursing wage increases:

> ***Ms SHEPHERD —*** *Some of their strategies that we have put up, we've just struck an agreement with government in relation to improved wages to bring nurses and midwives in Tasmania in line with the national average. Unfortunately, for instance, July 2022, our members did take industrial action at that time because of the fact we couldn't actually maintain safe staffing levels in line with the industrially agreed benchmark. At that time there was a range of strategies that were committed to by the Government in terms of providing support. Some of those strategies have been put in place, but, unfortunately, multiple wards and units across the state are still, almost 18 months on, yet to see clinical coaches implemented despite the Premier committing to those in July 2022.*
>
> ***CHAIR*** *— What is the hold up?*
>
> ***Ms SHEPHERD —*** *They are not funded.*

[59] Submission No. 37, Private witness, p. 4.
[60] Transcript of evidence, 23 January 2024, Dr Paul Scott, pp. 5-6.

CHAIR *— There has been a recruitment round table, or something like that, that ANMF was part of after the last election?*

Ms SHEPHERD — *Yes, that's correct. We've been asking for a period of 18 months.*

CHAIR *— It just hasn't appeared in the budget?*

Ms SHEPHERD — *No. They weren't funded positions and now the individual regions and hospitals are saying that they don't have budgets to be able to implement those positions. The work required to actually do the analysis around the wards and units where 30 percent or greater of the staffing establishment being made up of graduate nurses, enrolled nurses or those transitioning form other sectors, for instance, aged care to the acute sector, has only been done at one hospital rather than all hospitals to identify which wards and units need those clinical coaches.*[61]

FINDINGS

The Committee finds:

25. Transfer of care delays are a symptom of an underfunded Tasmanian health system that has not kept pace with community healthcare need.

26. The over-reliance on locum doctors and agency staff is an enormous expense to the Tasmanian Health Service.

27. The State Government has allocated insufficient funding to the level of nursing, paramedic, allied health and ancillary staff required to adequately run Tasmanian hospitals to national benchmarks.

28. Effectively dealing with the root causes of ambulance ramping will require significant additional investment by the State Government.

PRIMARY AND COMMUNITY CARE

2.55. A number of witnesses told the Committee that increasingly limited availability of affordable and accessible community and primary care, and consequent lack of timely treatment, is resulting in people becoming more unwell than they otherwise might. They argue this is contributing to an increased demand on hospital services.

2.56. Primary care is defined as a model of care that supports first contact, accessible, continuous, comprehensive and coordinated person-focused care.[62] Primary health care (PHC) is a broader whole-of-society approach with three components: (a) primary care and essential public health functions as a core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.[63] Primary and community healthcare services are those that deliver health care to people in a primary and/or

[61] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, pp. 11-12.
[62] World Health Organisation, https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care.
[63] World Health Organisation, https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

community setting, usually close to where they live and work and examples include general practice, dentistry, aged care and allied health.[64]

2.57. Department of Health (DoH) described the problems with lack of access to primary care in Tasmania, and how this contributes to an increase in transfer of care delays:

> *Poor access to appropriate primary care leads to people deferring care until health needs exacerbate and require hospital care or presenting to EDs with nonurgent conditions.*
>
> *While the Tasmanian Government has been investing heavily in primary care related initiatives, the Commonwealth has lead funding and policy responsibility for general practice and broader primary health care, as set out under the National Health Reform Agreement.*
>
> *…*
>
> *The Tasmanian Government has been, and continues to, strongly advocate for increased Commonwealth support for general practice and broader primary care in Tasmania. This has included requesting the Commonwealth urgently work with general practices and local communities to address thin and failing primary care markets to help ensure all Tasmanians have equitable access to primary care services in their community. Lack of access to GP services in local communities is a key factor impacting transfer of care delays. As raised earlier is this section, poor access to primary care can lead to worsening of conditions and a need for emergency care and/or hospitalisation that may otherwise not have been required.*[65]

2.58. Mr John Bruning, Australasian College of Paramedicine (ACP), commented that the lack of available primary care has necessitated paramedics being forced into picking up community healthcare duties:

> ***Mr BRUNING** — … I've been in my role eleven years, so I've had a good look what is going on as these challenges have increased. It really comes down to we are at this crunch point of less access to primary care in the community, seeing our patients in our community become more unwell because they cannot access care. Therefore, they're turning to other means to gain the care they need.*
>
> *This isn't a new experience for paramedics. It's been quite common in rural and remote areas that [we] become the only healthcare service when you clock off Friday at 5 p.m. until Monday at 8 a.m. There's nothing available for a lot of communities.*
>
> *Paramedics, for quite a while, have been drawn into doing what is not emergency response, but providing community healthcare. That issue of access to primary care is probably a key driver. … people are requiring care through the hospital system and through ambulance more often. But on the other side, we now have the hospitals getting full and patients aren't able to be safely discharged, we are then seeing that we get the bed block, an issue in the hospital. If we have someone of older age in a hospital, it's harder to discharge them out into the community if there's not*

[64] Australian Council on Healthcare Standards, https://www.achs.org.au/our-services/accreditation-and-standards/accreditation-programs/pch/nsqpch-standards#:~:text=DEFINING%20PRIMARY%20AND%20COMMUNITY%20HEALTHCARE,Aged%20Care
[65] Submission No. 64, Department of Health p. 9.

appropriate care for them. We are getting both ends causing the issue. There're more people going in and less people able to come out because we don't have fully integrated and accessible community healthcare. [66]

2.59. Mr Lucas Digney, Assistant State Secretary, Health and Community Services Union (HACSU) discussed the failure to invest in adequate primary and community health, and planning for workforce development. He attributes these failures as significant contributors to increased transfer of care delays and pressure on EDs, and emphasises the need for long-term investment:

> ***Mr DIGNEY*** *— What's going to solve it in the long-term, and permanently, Chair, is investment in primary and community health. There are too few allied health professionals in Tasmania for the population and the general wellbeing of the population. The statistics are clear about that. There are too few general practitioners and nurse practitioners and rural generalists available in Tasmania, and because of that, what we see is members of the community become unwell to a point where they never should have got if there had been adequate primary intervention, which sees them having no other choice but to call an ambulance or present to an emergency department.*
>
> *Whilst some of that responsibility, particularly around general practitioners, sits with the federal government, it's unclear what the state is doing to pressure their federal counterparts to fix that situation. Certainly, if any government wants a long-term and lasting solution to ambulance ramping and to capacity constraints and bed block in ED, then they have to make that investment, and if they don't, then they can expect the current situation to worsen because, ultimately, sick Tasmanians have very little choice at the moment. If you are not on a GPs books or you're not already in a community health service's round of patients, you're not going to get on their books or into that round and, ultimately, your condition will just get worse and worse and you'll get sicker and sicker until you end up in hospital.*[67]

2.60. Health Consumers Tasmania noted the difficulties with access to regional primary and urgent care services. They made suggestions around the provision of out of hours medical services to reduce the impact on ambulance callouts and to reduce the ramping problem in Hobart:

> *"A local triage clinic would actually reduce the pressure on ambulances and reduce the ramping problem in Hobart.", Huon Valley*
>
> *"Travel becomes more and more difficult – no Red Cross, community transport too expensive, bus takes hours and hours – but it is easy to call an ambulance. Using telehealth and making GP financial capabilities more attractive will directly reduce ambulance usage and therefore relieve the load on the Royal in Hobart" – Huon Valley*
>
> *"I'd like after hours medical service instead of having to calling ambulance. GP or a nurse triaging before GP." – Tasman Peninsula*
>
> *"It ties in with GPs not being available on the weekends. If GPs aren't available, people start presenting to the Emergency Department. And if the Emergency Department is full, that affects ambulances. I feel like more widely available GPs on weekends and after hours would be really helpful to the wider Royal Hobart Hospital bed-block ambulance ramping problem. We need weekend/after hours GPs to reduce reliance on*

[66] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p.3.
[67] Transcript of evidence, 14 December 2023, Health and Community Services Union, pp. 31-32.

ambulances and the Emergency Department, but also the ambulance services need to be improved." – Huon Valley[68]

2.61. Many submissions noted the overall decline in patients' health may be strongly influenced by lack of access, over time, to primary and community healthcare. Related to this, Rural Doctor's Association of Tasmania (RDAT) challenged the assertion that lack of access to primary care, at the time of presentation to the ED, is a major factor in transfer of care delays:

> *RDAT challenges the narrative posited by commonwealth and state governments that lack of access to timely primary care is a significant contributor to the access block that is a cause of transfer of care delays.*
>
> *While definitions of 'GP type presentations' (lower urgency) vary considerably based on the actual care that is provided to patients in the Emergency Department[5], these presentations, though they contribute to overcrowding, are not usually transported by ambulance, are normally seen within a 'Fast Track' or 'Ambulatory Care' stream separate from very unwell patients and those that need to be hospitalised, and are then discharged. They do not contribute to access block.*[69]

2.62. Similarly, Mr Matthew Carew, a former Launceston General Hospital (LGH) ED nurse, in his submission argued it is a false idea that too many people presenting to the ED for non-emergencies is the cause of increased ramping:

> *Political parties were either ignoring the issue, or suggesting having more GPs who were equipped to deal with emergencies were needed and calling this a fix to ramping. This just showed us there was a fundamental lack of understanding from government of the core issue, or a complete unwillingness to accept that the hospital needed a significant expansion to its inpatient capacity.*
>
> *Those patients who could be cared for by GPs were not the cause of ramping. People who didn't need a bed in ED and could be cared for by GPs were not allocated a bed. The few beds available would be highly prioritised to the most critical patients. Those who were beyond the care of GP and community services. These are patients whose conditions could not be prevented by regular GP care or acute access to GPs. The department was simply too full because there were not enough beds in the hospital to cater for the hospital's inpatient needs, and hence patients lingered in ED for days.*[70]

2.63. When questioning the Minister for Health, the Chair raised evidence presented that challenged the notion non-emergency presentations to the ED are a significant contributor to transfer of care delays. The Minister noted the effect that lack of access to general practice has on patients' health, and the low rate of bulk billing in Tasmania, compared to the national average:

> ***CHAIR*** *— … You've mentioned in the media a number of times when asked about the ramping situation, that 40 percent of emergency department presentations don't need to go to the emergency department and could be seen by a GP instead. We've had a number of people presenting to our inquiry refute that statement very strongly; people with medical expertise, researchers…*

[68] Submission No. 42, Health Consumers Tasmania, p. 5.
[69] Submission No. 57, Rural Doctors Association Tasmania, pp. 1-2.
[70] Submission No. 33, Mr Matthew Carew, p. 1.

Mr BARNETT *—... What I have said publicly and privately is that 4 out of 10, based on the information that's available to the Department of Health and is on the public record, are non-emergency. That's what I've made clear; it is 4 out of 10. That remains the case, and we can send you more information with respect to that figure. I've also highlighted on an ongoing basis the GP crisis, the bulk billing crisis that we have, and everybody knows that if you can't get to see your GP and or you don't go because of financial or cost of living reasons, it does have a flow on effect to your health.*

These are the concerns that I have, that's why I've raised it with the Federal Minister, my state and territory colleague ministers are raising it with the Federal Government. It's an issue all around Australia. I would table for the committee the most recent percentage of GP patients in each state and territory who are always bulk billed by the Department of Health. I'll table that document, it shows that all states and territories have pretty much between 60 and 70 percent, Tasmania 44.8 percent, it does have a flow on effect to the health and welfare of all Tasmania.[71]

2.64. Health Consumers Tasmania also noted the cost of seeing a GP was a factor in people delaying timely treatment, consequently becoming more unwell, and resulting in preventable hospital admissions:

The proportion of people in Tasmania who delay visiting a GP due to cost has risen from 6.9% to 8.7% over the five years to 2018/19. That's around 46,000 people in Tasmania who can't afford to see a GP. As bad as this number is, it has grown by nearly 10,000 Tasmanians over the last five years. GPs provide a critical first point of contact for people who become unwell, but what happens to those 46,000 Tasmanians who can't afford to see a GP when they should, or for those who don't have easy access to a GP.

More effort, funding and priority needs to be focused on how to support this group within our community so they have equal access into primary health care so GPs can treat them first before they move into acute care settings. This requires both state and federal government cooperation and intervention as the state funds hospitals whilst the federal government manages GPs (primary care).[72]

2.65. The Committee received many submissions which described the reality of increasing medical costs and the lack of affordable GP care, from members of the public such as Mr Rodney Jones:

Medical emergency and out of hours/ business hours GP treatment is expensive and many in our community cannot afford it. As a result, most are going to Medicare public-funded treatment facilities: LGH and RHH EDs and thus "clogging the system". People cannot afford GP visits these days, so we go to our Public Hospital and wait for a doctor to see you. Until the huge out of pocket or initial up-front costs are addressed, the resultant issue of ramping and clogged EDs will continue.[73]

2.66. Mr Brendon Flynn also similarly noted:

With fewer practice bulk billing and many practices not accepting new patients, what other alternative is there for people to present to the public hospital for emergency for treatment. My own GP now charges over $30 above the Medicare rate. Even as a

[71] Transcript of evidence, 8 February 2024, Minister for Health, pp. 18-19.
[72] Submission No. 42, Health Consumers Tasmania, p. 9.
[73] Submission No. 24, Mr Rodney Jones, p. 2.

pension care holder, there is no discount. This scenario has the effect of creating large waiting times.[74]

2.67. Health Consumers Tasmania believe the current primary care model, centred around the GP, is no longer suitable for the Tasmanian environment and its decentralised population. They made a range of recommendations to reform the primary care sector:

- *More and varied entry points to enter the system – not just through general practice*
- *Continued refinement and expansion of telehealth in terms of reach and usage – consumer driven not service provider driven*
- *Expand frontline placed based primary care workforce to include pharmacies, np [nurse practitioners]and cn [community nurses], peer workers, allied health*
- *Establish new roles or functions to provide continuity of care (navigation) across visits and health services*
- *Funding models that move away from transactional care to chronic condition management and coordinated care*
- *Patient information stays with the patient, not just the practice or premise*
- *Formalise and fund access to the social determinants of health – food, exercise, social activity, housing, transport etc into the system*
- *Every Australian has access to a free annual health and wellbeing check as a central component of primary care reform.*[75]

2.68. In their submission, Dr Jane Tolman, Ms Jeanette Palmer, Dr Stuart Walker and Dr Virginia Watson noted that nursing homes are too reliant on ambulance services for their elderly patients. They recommended that clinical staff in nursing homes be given the authority to refer a patient for ongoing clinical care to Community Rapid Response Services:

Many nursing homes are currently unnecessarily reliant on the ambulance service when a patient becomes ill or has a fall. Many of the current calls to the ambulance service could be averted if nursing home clinical staff were able to refer patients to the RRT [Rapid Response Team]. Now, nursing homes must rely on a GP for a referral to the RRT. Clearly this is not a functional situation. Giving clinical staff the ability to refer to the RRT would resolve this.[76]

2.69. Mr Tim Sloane, registered nurse who has worked in the ED, states the need for health care practitioners and the general community to be better educated about when to present to an ED:

Relieving the problem starts with the use of emergency departments. GPs, community health, and other allied health professionals etc. send patients to the emergency department for a variety of not necessarily valid reasons but these patients need to be fully assessed again by another health professional to determine whether they require

[74] Submission No. 10, Mr Brendon Flynn, p. 1.
[75] Submission No. 42, Health Consumers Tasmania, pp. 9-10.
[76] Submission No. 48, Dr Virginia Watson, Dr Stuart Walker, Dr Jane Tolman and Ms Jeanette Palmer, pp. 1-2.

further consultation. The culture needs to change and I guess litigation plays a big role here. In the ED it's possible to shuffle patients that don't need beds to accommodate ambulance patients but at some point, the options are exhausted. It sometimes feels like a never-ending game of Tetris.

Patients come to the ED because they have nowhere else to go to have their health complaints addressed. They seem to not know what an emergency is and what's not. Further education and campaigning is needed in this area. People also need not feel guilty for attending if they think that it is necessary.[77]

FINDINGS

The Committee finds:

29. A lack of sufficient and adequate primary and community care means many Tasmanians are unable to seek health treatment in a timely manner. This results in people becoming more unwell, and greater numbers of avoidable hospital admissions.

30. Nurse practitioners, community health workers, rural generalists, and allied health staff, are currently underutilised in community and primary care provision across Tasmania.

31. Tasmania currently lacks a strategy to increase the use of nurse practitioners, including training and employment pathways.

32. Tasmania does not have a rural healthcare workforce development plan which has exacerbated staff shortages and impaired access to services in regional Tasmania.

33. The lack of adequate investment in primary and community health in Tasmania, by state and federal governments, is leading to avoidable hospital admissions and additional pressure on ambulance callouts and Emergency Departments.

34. The lack of available primary and community care, especially in regional areas, has resulted in increased ambulance callouts, and paramedics being forced to undertake community healthcare duties.

35. Bulk billing rates and lack of access to General Practitioners can lead to people visiting Emergency Departments in search of free or subsidised healthcare. Although this is not a significant contributor to ambulance ramping, it is an increased burden on the operations and resources of ambulance services and Emergency Departments.

36. Avoidable hospital readmissions are occurring because people are unable to access appropriate post-discharge care in the community. These readmissions

[77] Submission No. 6, Mr Tim Sloane, p. 1.

place further strain on the hospital system, contributing to access block and transfer of care delays.

37. The current general practice primary care model may no longer be entirely suitable for the Tasmanian community and its decentralised population.

38. Clinical staff working within aged care facilities currently do not have the authority to refer patients to the Community Rapid Response Service for necessary care. This leads to an increased reliance on ambulance and Emergency Department services.

39. Extended care paramedics and community paramedics can assist in keeping aged care patients in facilities, and out of Emergency Departments.

40. The Hospital in the Home program is having a positive effect on reducing the number of patients requiring hospital-based care. It currently does not operate state-wide and has limits on patient numbers.

41. Telehealth in Tasmania is not being fully utilised in terms of reach and usage and does not properly focus on consumer needs.

42. Tasmania's district hospitals are currently underutilised and understaffed, and lack strategic planning including of infrastructure, workforce and clinical services.

Recommendations

The Committee recommends the State Government:

1. Bring forward the timeline for the Department of Health's masterplans for acute hospitals to have a delivery deadline of 2035.

2. Commit to a goal – supported by appropriate funding and operational plans – of reducing patient occupancy rates in major Tasmanian hospitals to 90%.

3. Develop a comprehensive plan to ensure the efficient and effective use of capacity in district hospitals.

4. Ensure all major hospitals employ a dedicated Emergency Department Navigator position to coordinate patient flow in and out of the Emergency Department.

5. Increase the number of allied health staff in public hospitals and expand shift coverage to match the operating hours of Emergency Departments.

6. Expand the availability of pathology and radiology services such that they are more in line with the operating hours of hospital Emergency Departments.

7. Undertake a review of the number of hospital cleaning staff required to ensure beds are cleaned and available for use and increase investment appropriately.

8. Appoint a person within the Department of Health with specific oversight and reporting on system-wide initiatives to address patient flow.

9. Expand, as rapidly as safely possible, proven effective measures for keeping patients out of hospital, including at-home care such as *Hospital in the Home*, and the use of community paramedics and extended-care paramedics.

10. Work with aged care providers to develop an interface system that gives hospital staff immediate intelligence of available beds in aged care facilities.

3. EFFECTS OF AMBULANCE RAMPING

3.1. Transfer of care delays can have significant impacts on the healthcare outcomes of patients waiting to be treated by ED staff and admitted as an inpatient, and on healthcare staff operating under substantially increased pressures – physical, emotional and moral.

3.2. Further impacts are observed on ambulance availability and response times in the community, and on the ED and other hospital functions.

3.3. All Tasmanian hospitals are experiencing extended transfer of care delays; however, the Royal Hobart Hospital (RHH) and Launceston General Hospital (LGH) are most effected.

3.4. In its submission, the Tasmanian Department of Health (DoH) recognised the impacts of transfer of care delays:

> *DoH recognises that delays in transfer of care do not support optimum care of patients, can negatively impact health outcomes and experiences of care for patients (including by contributing to prolonged discomfort), and be highly stressful for families and carers. Even when delays occur, patients are always under the care of a registered health professional. In addition to impacts on patients, carers and families, it is recognised transfer of care delays can also impact the morale and mental health and wellbeing of our dedicated and hard-working healthcare staff, including our paramedics, ED, and broader Tasmanian Health Service (THS) staff.*[78]

PATIENT CARE AND OUTCOMES

3.5. Transfer of care delays can have significant impacts on patients, with longer waits linked to an increased likelihood of harmful health outcomes. The Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch submission noted:

> *Prolonged transfer of care delays often leads to compromised patient care and outcomes. Delayed access to necessary medical attention can result in worsened conditions and increased mortality rates. Tasmanian Coroner reports over many years have cited overcrowded EDs as a contributing factor to patient deaths . . .*[79]

3.6. Dr Paul Scott, in the submission from the Royal Hobart Hospital Emergency Department, talked about the effects of transfer of care delays on morbidity:

> *Multiple studies in the medical literature recognise access block has a direct effect on mortality. Adverse patient outcomes and poor patient experiences are associated with ambulance ramping. Significantly, new patients presenting to an ED have a 10% greater chance of dying when more than 10% of patients waiting for admission are access blocked.*

[78] Submission No. 64, Department of Health, p. 3.
[79] Submission No. 36, Australian Nursing and Midwife Federation, Tasmanian Branch, p. 4.

In the RHH context that means patients are 10% more likely to die if we have three access blocked patients in ED. It is a rare day if we start below 20-28 patients who are accessed blocked. By extrapolation, the effect on mortality is obvious.[80]

3.7. Primary Health Tasmania also noted the negative effects of transfer of care delays on patients:

Transfer of care delays result in patients waiting in ambulances outside emergency departments, sometimes for hours, while their condition may deteriorate, or they may miss out on timely treatment resulting in longer hospital stays.[81]

3.8. The Australasian College of Paramedicine (ACP) submission spoke of the increased risk for patients delayed admission:

Ambulance ramping impacts patients detrimentally. Patients are likely to face delays in assessment and treatment, increased risk of exposure to error, increased length of stay in the hospital, worse health outcomes and increased inpatient mortality.[82]

Recent research from Aotearoa New Zealand has shown that new patients presenting to an ED have a 10 percent greater chance of dying within seven days of admission when experiencing delays in admission, while more than 10 percent of current patients waiting for admission in that ED are suffering access blocks.[83] *Additionally, up to three percent of hospital bed days result from waiting for imaging, consults and other waits that could be reduced.*[84] [85]

3.9. The Chair questioned Mr John Bruning of the ACP about this further:

CHAIR *— … a 10 percent greater chance of dying within seven days of admission after people have experienced delays in admissions. Could you speak a bit more to that relationship? …*

Mr BRUNING *— It's obviously really interesting data and it's fairly recent, just on a decade old. It's amazing that you think when you have greater than 30 minutes waiting there's a 10 percent increase in the chance of dying within seven days. That statistic continues to surprise, but also scare me that is an impact there. I can't give you a clear reason why that is occurring but, obviously, a delay to definitive treatment at times is impactful for some patients.*

We've obviously seen in the media recently about an ambulance not going to people in time and resulting in death. It is a terrible outcome to what is a health system in distress. I think our goal is that there are people who need definitive care urgently and delays for them have a significant impact. That's the bit of what an ambulance, a paramedic and the emergency department are really designed to deal with and it's the other things — the lack of staff or the lack of access to care — that are creating extra wait times for those more urgent patients.[86]

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[80] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 3.
[81] Submission No. 55, Primary Health Tasmania, p. 6.
[82] Access block, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-forPatients/Access-Block, referenced in Submission No. 54, Australasian College of Paramedicine, p. 4, footnote 21.
[83] Werf. B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand, referenced in Submission No. 54, Australasian College of Paramedicine, p. 4, footnote 22, Chalfin, et al., 2007.
[84] Cameron PA, O'Reilly GM, Mitra B, Mitchell RD. Preparing for reopening: An emergency care perspective. Emergency medicine Australasia. 2021;33(6):1124-7, referenced in Submission No. 54, Australasian College of Paramedicine, p. 4, footnote 23.
[85] Submission No. 54, Australasian College of Paramedicine, p. 4.
[86] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 4.

3.10. Mr David Pittaway, a registered nurse and ED Navigator, noted that patients experiencing transfer of care delays are limited in the care they can receive, even though they are within a hospital. This is as they are yet to be admitted to the ED and the paramedics caring for these patients are limited in their scope of practice:

> *The major problem for TOC [transfer of care] patients is that these same paramedics have defined scope of professional practice (SOP), which differs significantly from the ED nursing scope of practice. As such, TOC patients can have delays in having common medications administered (e.g. intravenous medications and some IV fluids) or common interventions (e.g. nerve blocks to relieve the pain of bone fractures, esp. neck of femur fractures) simply because they are in TOC. This is not a criticism of AT, it is a reality of bedblock.*
>
> *In contrast, a patient in the waiting room might get the IV medications because they would be classed as under the care of the ED.*
>
> *When staffing allows, one or two CINs (Clinical Initiatives Nurse) are available to the TOC area to begin treatments as prescribes by ED doctors, provided the TOC crews allow these to happen. This generally depends on how strictly the TOC staff comply with their SOP. In my experience, some AT staff are prepared to go out of their SOP for what they see as benefiting their patient/s, while others quite rightly refuse to do so, knowing their patients are not getting the care they otherwise might. This must be quite a moral challenge for AT crews of both attitudes.*[87]

3.11. Paramedic, Mr Ryan Posselt, was asked to describe how ramping could lead to worse health outcomes for patients:

> ***CHAIR** — In your submission, you said that ramping places patients at risk of worse health outcomes, and you provided a number of examples. …, can you provide an overview of the ramping process and why it puts patients at risk? . . . you're a very skilled paramedic, you're sitting there with [a patient], why are they at increased risk on the ramp?*
>
> ***Mr POSSELT —** Any delay to care in certain groups of patients will result in worse outcomes. There's lots of literature and evidence to support that. Examples include major heart attacks, strokes, infection. If you have a patient who has a very bad urinary tract infection and their body is responding in a manner that we refer to as sepsis, which is a type of inflammatory response that places you at risk of death, every hour without antibiotics increases your risk of dying. Paramedics can give antibiotics to some patients, but these types of patients sit in the grey area where paramedics are not allowed to administer antibiotics, but they do need antibiotics at the hospital and they may need a specific type of antibiotic.*
>
> *We know that antibiotic resistance is a problem globally and antibiotic stewardship is important. Paramedics only carry one antibiotic which is a very high-powered, broad-spectrum antibiotic and it may not be the best antibiotic for something like urinary tract infection. These patients aren't quite sick enough to earn themselves a resus[citation] bed and they end up coming around to the ramp area, often not being seen within the desired time frame.*

[87] Submission No. 46, Mr David Pittaway, pp. 6-7.

I read that our time to be seen within the clinically recommended time frame is somewhere around 30 percent now. That means these patients who should be seen within 20 minutes might not be seen with[in] 40 [minutes] or an hour.

We just sit and give them fluids in the case of an infection and wait. We can advocate for them, but if the department is chaotic – and it's not the department's fault, it is absolutely nothing to do with the emergency department, they're working their butts off in there – but if we wait an hour [for a patient] to be seen by a doctor, it then takes 25 to 30 minutes to find a nurse to administer the antibiotics. Technically, per the directive we have from the ambulance service, we are not allowed to have those antibiotics administered while the patient is in our care, because it is not within our scope of practice.[88]

3.12. Many submissions by paramedics discussed the limited privacy available for patients on the ramp, with patients regularly experiencing loss of dignity as a result. Private witness 16 noted:

When patients are ramped they were/are also exposed to patients being moved into, or going directly into a resuscitation bay. On multiple occasions I have taken patients post cardiac arrest, or traumatic event into a resuscitation room in the view of ramped patients, exposing them to the traumatic event and providing little privacy or dignity to the patient.

Whilst ramping in the corridors it was commonplace to undertake 12 lead ECGs on patients, both male and female. Risking exposing them to others on the ramp, as the ECG placement goes directly onto the chest of the patient, around the left breast. Whilst every attempt can be made to ensure privacy, this is no doubt an awful experience for the patient and is certainly not dignified.

Whilst ramping in the corridor it was not unusual to see or have to assist a patient to toilet in the corridor. Whilst every attempt is made to ensure privacy it is quite obvious to those around that the patient is toileting. This would occur as the "ramping room" would have patients in it and a bed will not fit into the "relatives room" and all other rooms were full. There was literally no place for a patient on a bed to toilet privately. If the patient was well enough, they could be put onto a commode or wheelchair and taken to the toilet, but for those too unwell on a bed, there were no other options.[89]

3.13. Private witness 5 also spoke of the lack of privacy for patients who are ramped:

How can a health care worker examine a patient in private. You can't toilet them. Doing an ECG to look at their heart is a project because there is no private space to remove their gown and place dots on their chest, connect an ECG machine and look at heart patterns and rhythm. Just simple assessment.

You expect quality care and good decision-making in a very suboptimal environment where the basic work cannot be done and expect no deaths. You expect no mistakes. You set the staff up to fail with a patient who is sick who cannot be examined.

No privacy. How do you expect us to toilet a patient in the hallway when they can't walk?[90]

[88] Transcript of evidence, 11 December 2023, Mr Ryan Posselt, pp. 7-8.
[89] Submission No. 16, Private witness, pp. 2-3.
[90] Submission No. 5, Private witness, p. 1.

3.14. In his submission, Mr Pittaway, also talked about how patients can be affected by extended stays in the ED, including:

> *. . . the development and/or exacerbation of delirium, a state of confusion which is known to be made worse by patients, especially the elderly, not being exposed to natural light. It is not the light as such that helps them, it is being able to see whether it is day or night. At present, and for the foreseeable future, patients in the RHH ED and the EMU have no access to windows, and thus natural light. We already have big problems with confused patients, who require constant observation to ensure they stay safe, without making their problems worse for them, simply by still being in the ED.*[91]

3.15. Patient care can also be compromised by the fact there is concern among some in the community about calling an ambulance. Several submissions to the Committee noted a hesitation expressed by people in the community about calling an ambulance for fear they may be ramped at a hospital and their care compromised. The Health Consumers Tasmania submission noted:

> [when asked what they do if they are unwell after hours] *"We're stuffed. I waited for 1.75 hours for the ambulance to come from Glenorchy with a twisted bow[e]l. I was that ill I passed out. The person on the phone asked me to stay with her. I was in and out of consciousness. Little did I know my neighbour was the volunteer ambulance driver on call – so her buzzer went off and she came over – she couldn't give me any help really, but she stayed with me.", Dover/Geeveston*
>
> *"Unless someone had a heart attack, I wouldn't call an ambulance because that could take a couple of hours.", Dover/Geeveston*[92]

3.16. Health Consumers Tasmania also provided evidence about people feeling guilty for using ambulance services because of the ambulance ramping pressure, and been disinclined to call for help:

> *People tell us they are very aware of the overloading of the ambulance service and the emergency department and they may put off calling an ambulance in order to avoid putting more pressure on the system or taking service away from someone else, especially if there is only one ambulance in the area.*
>
> *"I find there's a guilt factor about calling an ambulance – there may be people who are worse off.", Tasman Peninsula*
>
> *"I have required the ambulance service. I still am hesitant to call an ambulance when I may have needed it though, due to still feeling like I don't want to take that service away from where it may be needed more.", Tasman Peninsula* [93]

3.17. Private witness 5 also expressed concern about people avoiding hospitals due to transfer of care delays and the negative patient outcomes associated with this:

> *People are delaying coming to hospital to get health care because of the negative publicity. They do not have confidence in our healthcare system to deliver care to*

[91] Submission No. 46, Mr David Pittaway, p. 7.
[92] Submission No. 42, Health Consumers Tasmania, p. 4.
[93] Submission No. 42, Health Consumers Tasmania, p. 4.

them. What does this mean? When they do come into hospital, they are sicker, they have to stay in longer to recover.[94]

3.18. Many paramedics spoke of their distress at being stuck on an ambulance ramp while listening to triple-0 calls going unattended to due to a lack of available ambulances. They expressed distress knowing people were waiting sometimes hours without medical help. Ms Megan Cube described how the long wait for an ambulance negatively impacted her mother's access to timely care, with her mother dying five days later:

On Friday 24 March at around 8pm, my sister was contacted by Korongee staff, who said that my mum wasn't well, with stomach pains, and they had called an ambulance. They said they would phone back when the ambulance arrived, so we could meet them (with mum) at the hospital.

At around 11pm we contacted Korongee, as we hadn't heard anything from them. They told us that the ambulance hadn't arrived yet; but that they had called again requesting assistance. …

The ambulance finally arrived . . . 6 hours after being called. In those 6 hours, my mum's pain became worse. She could not keep anything down, and so had not had any kind of pain relief (ie Panadol). She was very distressed. Korongee staff told me that they had called for the ambulance either 3 or 4 times, and had stressed to the dispatcher that they weren't calling because a dementia patient was 'acting out', but that there was a genuine, medical issue. Staff were told that all ambulances were on other calls or waiting at hospital. …

About 5am, after being scanned and checked by medical staff, I was told that mum had a perforated bowel. She died 5 days later.

My mum wasn't one of the patients stuck in Emergency for hours and hours before ambulance staff could hand her over to hospital staff. However, I do believe she was still a 'victim' of ambulance ramping — if the system were better, and patients able to be handed over more quickly, mum would not have had to wait 6 hours for the ambulance [to] arrive.[95]

3.19. Ms Stella Jennings spoke to the Committee about the experience of her mother's death, who had experienced an extended transfer of care delay, and her subsequent fears of what might happen if she or a family member are required to attend the Launceston General Hospital (LGH) for treatment in the future:

CHAIR *— We talked about the trust deficit before. How has this impacted how you feel about going to the Launceston General Hospital?*

Ms JENNINGS *— We are terrified that one of our kids or one of us will be sick or Dad is not in great health, and it's terrifying. I have to go to the hospital, I don't work in the medical field, but I work through the NDIS, and I quite often have to visit the hospital to see some of my participants there, and it makes me ill. I feel sick walking into the hospital just for my participants, imagine if it was my family. It literally keeps me up at night, worrying. If the kids get a little bit sick, I think — I'm not a panicker, I'm not that kind of person. My children are not tiny. I was never this panicky even when they*

[94] Submission No. 5, Private witness, p. 1.
[95] Submission No. 28, Ms Megan Cube, pp. 1-2.

were babies, but now I worry that they just aren't going to get the care. We were so blithe about it.

We lived in Melbourne many years and we moved here four years ago. I love Launceston, and we love everything about living here. We just didn't realise that the health system, comparatively, is in such bad repair. So many things are falling through cracks. So many things that just aren't there that you'd expect to be there are not. I don't know what we'll ever do if one of us has to go to the hospital, but I can tell you that we are all really anxious about that in our family now.[96]

3.20. The non-availability of pathology and radiology services outside of hours at the LGH was a significant issue that worsened the impact of transfer of care delays, leading to the death of Ms Jennings' mother. Ms Jenning wrote:

My mother, Anne Pedler, died on August 6th 2022 after being ramped at the LGH for in excess of 8 hours. . .. my mother presented to the LGH with a working diagnosis of a pulmonary embolism (PE), which is potentially life threatening, and despite being triaged as urgent, she was not transferred to the care of the LGH at any stage, even when she had rapidly deteriorated and subsequently passed away.

…the main issue had been a delay caused by waiting for pathology results, which were never followed up. It transpires that there is no 24/7 pathology on site at the LGH, so this is "outsourced" and can go to a lab on the mainland, or even overseas. The tests were ordered but, as my mother was not an admitted patient, there was no one assigned to follow the results up. Medication for the PE was withheld pending these results, which, the coroner notes, would have increased her chances of survival as "30% of untreated patients die, while only 8% succumb with effective therapy". Even had the pathology results been returned, she would then have likely been sent for a scan, which again, would likely have been delayed as there is also no 24/7 radiology on site at the LGH, and an "oncall" service is used, causing further delays in patient care and, presumably, wait times for patients to be transferred to the care of the LGH.[97]

3.21. This lack of 24-hour pathology was discussed with Ms Fiona Liutier, CEO of the LGH, Mr Joe McDonald Chief Executive Hospitals South, Ms Kathrine Morgan-Wicks, Secretary of the Department of Health (DoH) and Mr Dale Webster, Deputy Secretary DoH, with a review underway into pathology services:

Ms DOW *— . . . given the findings of a number of coronial inquiries recently, I want to understand what measures are in place to make, for example, 24-hour pathology available in the Launceston General Hospital?*

Ms LIEUTIER *— The arrangements at the Launceston General Hospital are that we have on-call services outside of the working hours of our radiologists and pathologists. It's a 15-minute call-back. The advice I've received is that 24-hour radiology services is not common in hospitals and that our 15-minute call-back is consistent with most other major hospitals. In terms of pathology, again we have after-hours call-back for urgent pathology tests and there's no barriers to call-back. I believe that 24-hour call-back may be considered as part of the statewide review of pathology but not individually by the LGH at this time.*

[96] Transcript of evidence, 8 November 2023, Ms Stella Jennings, p. 16.
[97] Submission No. 44, Ms Stella Jennings, p. 1.

...

***Mr McDONALD** — ... At the Royal we have staff on call both for pathology and medical imaging. I recently discussed this with Dr Scott, the clinical director of the emergency department, if there were any barriers to any diagnostics. The feedback Paul gave me was that there wasn't, that he's got enough diagnostics both around pathology and medical imaging because the service, be it call-back or the staff that were still there, were still providing that for him and he didn't perceive any delays there.*

...

***Mr WEBSTER** — . . .We have a different model of pathology in Tasmania to most of the other states and territories. We are, at the moment, having a look at our delivery model of pathology. A number of our clinicians have spoken to us about extending that from pathology to diagnostic services and we are looking at that as well. We acknowledge that our model might not be best practice, and we are in the process of doing that comparison, particularly with the other states and territories, and redoing our model to make sure that we are keeping pace with the other states and territories.*

***Ms DOW** — When would you expect that review to be completed?*

***Mr WEBSTER** — . . . What I should say is that a fairly detailed review was done independently but we're now working with our clinicians on what that looks like specifically for Tasmania. The timeline on that project is 12 months.*[98]

FINDINGS

The Committee finds:

43. Transfer of care delays directly and negatively affect the treatment of patients, leading to increased morbidity and mortality rates.

44. The scope of practice for paramedics is not designed for hospital-based care.

45. The care available to ramped patients is limited to that available within the scope of practice for paramedics. This means a ramped patient, compared to an equivalent Emergency Department waiting room patient, is at greater health risk because they cannot access the full range of necessary medications (including pain relief and antibiotics) and interventions (including diagnostic tests) that are available within the Emergency Department.

46. Ambulance ramping delays increase the risk of a patient suffering an adverse event. There is a ten percent greater chance of dying within seven days for people who have experienced ambulance ramping.

[98] Transcript of evidence, 5 February 2024, Department of Health, pp. 32-33.

47. There has been a significant increase in the number of Category 2 (very unwell) patients who have been subjected to ramping despite the risks to their health.

48. Transfer of care delays lead to a lack of appropriate spaces to assess and treat patients, leading to distress and a loss of dignity and privacy for patients.

49. Some people in the community avoid seeking emergency care when they really need it due to fear of experiencing ambulance ramping, or because they feel guilty about potentially taking ambulance resources from others in need.

50. A lack of 24/7 pathology and radiology services can result in adverse outcomes due to the delay in care from waiting for results.

AMBULANCE RESPONSE TIMES AND AVAILABILITY

3.22. Transfer of care delays have a very real impact on the availability and response times of ambulance services. When an ambulance is ramped, it is no longer available for callouts. Often ambulances that are delayed at hospitals may come from rural and remote stations, leaving those communities without readily available emergency care for a lengthy period of time.

3.23. The Department of Health (DoH) noted there has been a huge increase in the need for ambulance services in recent years, with the number of ambulance dispatches increasing by approximately 93 percent between 2009-10 and 2022-23.[99]

3.24. DoH also provided the following evidence in relation to the number of ambulance dispatches and their response times:

> *Ambulance Tasmania's Statewide Median Emergency Response Time to incidents in 2022-23 was 14.5 minutes, and 14.3 minutes in 2021-22. Ambulance response times are directly impacted by demand for, and availability of, resources in the community. During times where high transfer of care delays are being experienced, Ambulance Tasmania seeks to deploy additional paramedics to public hospitals to support patient care and enable ambulance crews to be released to continue to provide ambulance services in the community.*
>
> *...*
>
> *As with demand for ambulance services, ambulance arrivals to EDs have also significantly increased in recent years. ... over the last 14 years ambulance arrivals to Tasmania's public EDs have risen by 57.4 percent, from 33 672 in 2009-10 to 53 002 in 2022-23 (these figures do not include Ambulance Tasmania helicopter arrivals, mortuary ambulance arrivals, and private ambulance arrivals).*[100]

3.25. In its submission, the Health and Community Services Union (HACSU) outlined the effects transfer of care delay has on ambulance response times and availability, including delayed response times, increased call volumes, impacts on rural communities, and healthcare worker burnout.[101]

[99] Submission No. 64, Department of Health, p. 15.
[100] Submission No. 64, Department of Health, p. 16.
[101] Submission No.53, Health and Community Services Union, pp. 6-7.

As paramedics remain at hospitals with patients due to ramping, they are unavailable to respond to new emergency calls promptly. This results in longer waiting times for individuals in critical need of medical assistance, amplifying their suffering and increasing the risk of adverse outcomes.

...

As more ambulances are occupied with patients awaiting transfer, fewer units are available to answer emergency calls. The performance reports demonstrate that this increased demand often surpasses the capacity of the ambulance service, creating a backlog of emergency requests.[102]

3.26. Dr Paul Scott, Acting Director, Royal Hobart Hospital (RHH) ED, provided an example of how transfer of care delays can result in poor patient outcomes due to unavailability of ambulances:

There is good evidence to show that TOCDs also delay access to definitive assessment and care because of slowed ambulance response times, including clear evidence of increased 30-day rates of death. Anecdotally we have firsthand knowledge of paediatric cardiac arrest on the Tasman Bridge due to unavailability of an emergency ambulance (whilst multiple ambulances were only 2 kms away at the hospital unable to offload their patients).[103]

3.27. The impact of transfer of care delays on ambulance availability and response times is particularly acute in rural communities. Rural Doctors Association Tasmania (RDAT) raised concerns at solo paramedics working without support, rural communities being left without ambulance services for very long periods, and rural hospitals assuming greater risk through being required to care for critically ill patients longer:

Ambulance ramping increases the poorer access to ambulances already being experienced by rural people. Ambulances are taken out of rural areas for longer, markedly worsening availability, slowing response times and increasing the likelihood of poorer health outcomes.

...

RDAT members have observed that all urban ambulances can be ramped simultaneously at major hospital Emergency Departments leaving no community cover, except for urgent 'P0' and 'P1' cases. This means that paramedics are rushed to handover their current patient to either another crew or the hospital, clean and restock their vehicle and respond to the time-critical call outs.

The impact on ambulance response times is particularly exacerbated in rural areas, where there is often only one paramedic for an entire rural region. With no rendezvous crews available trip times are significant and creates management of paramedic fatigue issues. In areas where there are no GPs people are more likely to call for an ambulance. Ouse, in the Central Highlands is in a district where there are no GPs, no District Hospital and a downgraded community centre. It has been reported that a single case from Ouse can take over 6 hours to return to the area and be ready to respond to the next case.

[102] Submission No. 53, Health and Community Services Union, p. 6.
[103] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 3.

Often these solo paramedics work without volunteer support. This means that rural communities must wait for a crew to become available from the city to respond to a primary call-out from the community to a major hospital or to rural interhospital transfers retrieval requests.

RDAT understands that interhospital transfer times from rural Emergency Departments to large Emergency Departments have also increased significantly in the past few years. This has meant that rural hospitals are taking on a large burden of risk that they are not resourced for as they care for critically unwell patients for longer. RDAT urges the Committee to further inquire into this issue.[104]

3.28. The submission from Primary Health Tasmania also spoke of rural communities being without ambulance services for long periods:

Transfer of care delays also reduce the availability of the ambulance fleet to respond to other emergencies, with remote and rural areas being at particularly high risk for this given the already limited number of ambulance and paramedics in these regions.

This is further exacerbated in Tasmania due to the state's dispersed population and geographical distance/travel time between ambulance stations. The effect of transfer of care delays is particularly felt by both healthcare providers and people in rural areas and sometimes affects how, or even if emergency services are accessed.[105]

3.29. Private witness 18 also provided an example of a remote community left without ambulance services for long periods due to their single ambulance and paramedic being stuck on the ramp at a regional hospital:

… the reason our remote community is left without local ambulance services for lengthy periods of time — which manifests in response delays — is absolutely 100% related to ramping! When we are required to transport patients to the regional hospital an hour away in Burnie, and we are stuck there, ramped, our community is left without any emergency response resources! As a Branch Station with only one ambulance and only one paramedic rostered on at a time (for 96 hours straight!!!!) we are extremely vulnerable when more than one medical emergency happens at once. In the event of a medical emergency occurring while we are completing the three to four hour [r]ound trip to the NW Regional Hospital with a patient, a crew has to be dispatched from Wynyard or Burnie (if there is one available) to rush under lights and sirens for 80 kilometres over the worst roads in the state, to respond![106]

3.30. The Committee received a number of submissions with harrowing personal stories of Tasmanians waiting long times for ambulances to arrive, and of severe health consequences that resulted, sometimes including death. Ms Helen Hussey wrote:

On 2nd January 2022, my partner of 26 years, Nelson Mariner, died while waiting for an ambulance. He was living in East Yolla, in North West Tasmania. At the time I was shocked and had to deal with the police and the Coroner. He had rung for the ambulance, having difficulty breathing. They were talking to him on the phone, when he no longer responded. Throughout the whole drama, I remember that at one time

[104] Submission No. 57, Rural Doctors Association Tasmania, pp. 4-5.
[105] Submission No. 55, Primary Health Tasmania p. 6.
[106] Submission No. 18, Private witness, p. 1.

the policeman saying that if the ambulance had got there sooner, he may have still been alive. I don't know how long he was waiting.[107]

3.31. Mr Rodney Jones shared the traumatic experience of his elderly neighbour in Launceston waiting two hours for an ambulance following a fall. Two regional ambulances, both understaffed, finally attended the callout, leaving their communities of George Town and Deloraine without an ambulance:

> *In February this year 2023, my 87 year old, female neighbour had a serious fall down her back steps which resulted in her lying and being trapped on top of her walking frame and crying for help.*
> *...*
> *An ambulance was rang for, via the 000 emergency services at about 6pm. An ambulance was "booked" and the male operator gave us directions to stabilize the elderly lady until help arrived.*
>
> *After about 45 minutes the lady was naturally getting very cold and more in pain. We comforted her and supported her head as directed which 2 of us took turns in doing. We placed several blankets on her and tried to reassure her.*
>
> *After an hour. . .no ambulance. We were getting very annoyed and tired and the patient was suffering even more! We redialed [sic] 000 and was told that our ambulance was in the queue and the next available would be sent. No ambulances were available in the Launceston area at that time as all were on call-outs or at the LGH!*
>
> *After another 30 minutes it was too much. We redialed [sic]000 very annoyed, and said the lady was in shock and we needed to get her up somehow and get her to hospital as her head was bleeding badly from the fall and she was very cold. We were told an ambulance was dispatched and on its way. . . About 20 minutes later (Nearly 2 hours from the initial call to 000) an ambulance arrived with 1 driver only ! She was from the Georgetown Station and was awaiting backup!*
>
> *She assessed the lady and reassured her she would be ok. The second ambulance and single driver arrived about 10 minutes later. . . . . from Deloraine! They said that both Deloraine and Georgetown were then without ambulances due to attending our patient in Launceston!*
>
> *...*
> *After talking to her about 2 weeks later when home, she said the care was absolutely fantastic, but she was kept in the ambulance at the waiting bay for about another 2 hours until the ED could see her.*[108]

3.32. Ms Mavis Doran also wrote of her three hours wait for an ambulance:

> *I am 93 years old and two weeks ago I fell and fractured my pelvis. An ambulance was called and took 3 hours to get to me, and I arrived in RHH at about 4.30pm. I was ramped until nearly midnight before being transferred to the Emergency Department proper. I was then taken to a ward at 4.00am!*[109]

[107] Submission No. 21, Ms Helen Hussey, p. 1.
[108] Submission No. 24, Mr Rodney Jones, p. 1.
[109] Submission No. 32, Ms Mavis Doran, p. 1.

3.33. A number of paramedics also wrote with many experiences of the impact of transfer of care delays. Mr Peter Mulholland, a retired intensive care paramedic:

> *Having worked in a rural area, on most occasions when taking patients to Launceston General Hospital (LGH) we would be ramped. This left the rural area without ambulance response for several hours at a time. Some examples included patients experiencing falls at home and waiting up to 4 hours for an ambulance. In at least one instance a patient has suffered a stroke, in another, a fractured hip. Where possible ambulance dispatch would attempt to have a local ambulance volunteer attend, however a shortage of volunteers meant this was rare. This has been helped in the last year with the opening of another rural station in a close area, however, this ambulance has to be available and volunteers are again scarce. Backup for this ambulance is still only possible from the Launceston area (if not ramped).*
>
> *When ramped with a rural patient at the LGH and a category one case occurred in the rural area, rather than the rural ambulance being allowed to 'unramp' a free crew was often sent from Launceston or Mowbray (if available). Again this led to delayed response, crews were unfamiliar with local areas, and towns crews would sometimes incur unreasonable shift extensions due to the time involved in responding then returning.*[110]

3.34. Submissions also outlined the extreme difficulties faced by single officer paramedics, working without back up because of transfer of care delays, in their ability to appropriately care for patients. Private witness 16 noted:

> *I attended a case where I was a single officer, I was told my backup was coming from close by. On arrival the patient was unwell with a significant gastric bleed, after waiting for my back up to arrive for some time, I called to enquire of their location, only to be advised that communications had cancelled them and sent them to another case – this is against the policy of single officers and back up. I was told I could have a backup crew if they could get one off the ramp. I was located in Orielton at the time, I was then advised that all other crews were ramped and I would have to wait for an afternoon shift to start. I decided to travel with this patient on my own, advising Communications that they had subsequently put the patient and myself at risk by cancelling my backup without consultation and I now has the choice of staying at the location and the patient deteriorating or leaving and providing inadequate care but being closer to assistance. When arriving at DEM there was a prolonged time to tirage >10 min, and then the patient needed to toilet (with only me to assist), triage wanted blood tests and pending those, the patient was ramped – the on road duty managers called me 3 times to see what I was doing despite being able to see me on camera at the RHH.*
>
> *- On the same day as the above case, I attended a case at Howrah (from my station at Sorell because I was the closest crew to that emergency), as a single officer. Again there was no backup dispatched to me, as per the policy, due to ramping of crews and no one available. This patient was also unwell and had difficulty extricating – again there was no backup available to assist and I decided to transport the patient by myself. This patient had a pulmonary embolus, and the care enroute was inadequate. Again, the on road duty managers called me – 4 times.*[111]

[110] Submission No. 35, Mr Peter Mulholland, p. 1.
[111] Submission No. 16, Private witness, p. 1.

FINDINGS

The Committee finds:

51. There has been a significant increase in demand for ambulance services in Tasmania in recent years.

52. Ambulance ramping leads to fewer ambulances being available to respond to ambulance callouts, leading to delayed ambulance response times (including for emergency calls).

53. Longer ambulance ramping times are associated with increased pain and suffering for patients and greater risk of adverse health outcomes.

54. Transfer of care delays have a disproportionate negative impact on rural communities. Ambulances from these communities that are ramped at major hospitals leave regions without local ambulances available to respond to callouts.

55. Ambulance ramping constrains paramedics to the hospital in order to care for ramped patients. This can result in single paramedics having to attend jobs without back up.

56. Ramping increases costs to the Tasmanian Health Service, including the cost of having paramedics not fulfilling their primary role.

57. Inadequate staff numbers in Ambulance Tasmania are exacerbating the effects of transfer of care delays and increased demand for ambulance services.

58. The operational effectiveness of Ambulance Tasmania would benefit from having more permanent staffing contracts.

59. Community care paramedics, extended care paramedics, secondary triage, telehealth and other measures are showing some signs of mitigating the effects of ambulance ramping and delays in ambulance response times.

WELLBEING OF HEALTHCARE STAFF

3.35. Transfer of care delays have a seriously negative impact on the mental wellbeing of paramedics and Emergency Department workers. The Health and Community Services Union (HACSU) described these impacts as including burnout, stress, anxiety, depression, post-traumatic stress disorder and moral distress.[112]

3.36. The Australasian College of Paramedicine (ACP) submission described the causative relationship between transfer of care delays and mental health impacts. They outlined how transfer of care delays leads to workplace issues experienced by paramedics and ED staff:

Impacts on paramedics:

[112] Submission No. 53, Health and Community Services Union, pp. 8-9.

Ambulance ramping and access blocks impact paramedics in several ways. Paramedics exposed to ramping identify many negative experiences (verbal abuse, physical abuse, compromised patient care, and patient fatality).[113] *These negative experiences contribute to high depression, anxiety, stress, and post-traumatic stress disorder symptoms.*[114] *Ambulance response times in the community have deteriorated whilst ambulances are ramped at hospitals. This leads to worse health outcomes for those in the community with life-threatening emergencies waiting for an ambulance response, with more severe cases spending more time ramped before offload.*[115]

The Senate Inquiry into mental health of first responders, 2019, made several recommendations to support mental health of first responders.[116]

Impacts on ED Staff:

Ambulance ramping and access blocks ramping lead to workload issues such as missed meal breaks, overtime, independent feelings of frustration and responsibility for the potential harm to patients waiting for care, which adds to the strained relationship with paramedics.[117] *In 2019, access block and ED overcrowding were identified as the top workload stressors for ED staff.*[118] [119]

3.37. In verbal evidence Mr Lucas Digney and Ms Simone Haigh, representing HACSU, spoke of the psychological and emotional impact of ramping on healthcare staff, and the effect this has on the capacity of Ambulance Tasmania to maintain its workforce:

CHAIR *— In terms of the support HACSU is providing members, how has that been influenced by the growth of ambulance ramping? What is the effect you are seeing on people and how has that affected your work?*

Mr DIGNEY *— What we are seeing is increasingly paramedics becoming affected by emotional and psychological stress, so, increasingly, they are lessening their hours of work; increasingly, they are taking sick leave; increasingly, they are working shorter shifts. And, increasingly, they are coming to us asking, 'What can we actually do to make this stop because we cannot deal with it any more'. It is coming to the point where they are looking for any type of solution that can be found.*

Ms HAIGH *— Just to add to that, all the decreasing in the work hours, sick leave and workers comp for mental health, there is no sort of fat in the system to cover those people on-road. So, not only are they getting exhausted from all the ramping and just*

[113] Sullivan C, Staib A, Griffin B, Bell APA, Scott API, Hospital PA, et al. The Four Hour Rule: The National Emergency Access Target in Australia Online: Queensland Government; 2016, referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 29.
[114] Phillips, W. J., Cocks, B. F., & Manthey, C. (2022). Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. https://doi.org/10.1037/tra0001241, referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 30.
[115] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022, referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 31.
[116] Parliament of Australia Inquiry. (2019). The people behind 000: mental health of our first responders. [cited 13/10/2023] Available from: The people behind 000: mental health of our first responders – Parliament of Australia (aph.gov.au), referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 32.
[117] Phillips WJ, Cocks BF, Manthey C. Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, & Policy. 2022; Publish ahead of print, referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 33.
[118] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-EmergencyMedicine/Better-Outcomes-for-Patients/Access-Block, referenced in Submission No. 54, Australasian College of Paramedicine, pg. 5, footnote 34.
[119] Submission No. 54, Australasian College of Paramedicine, p. 5.

constant work without a break; they are also running crews down and that is happening statewide.[120]

3.38. Similarly, the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch noted the impact of excessive workload on staff and the quality of care they are able to provide:

> *Excessive delays place an enormous burden on healthcare staff, particularly from a workload perspective due to overcrowded EDs and the constant pressure of trying to move patients through quickly right across the hospital, leading to moral injuries, burnout, and mental health issues. This negatively affects the quality of care provided, despite every nurse and midwife working to their absolute maximum.*[121]

3.39. Dr Paul Scott described the regular working experience common to doctors and nursing staff in his ED at the Royal Hobart Hospital (RHH):

> *… I have 27 acute bed spaces to manage lay-down patients in the Emergency Department. Almost every morning we have 20 to 30 admitted inpatients occupying those 27 bed spaces. On a good day, perhaps if we have 24 admitted patients, I have three lay-down bed spaces in the Emergency Department to deal with 209 admissions which I have on average through the day, knowing very well that 40 percent of them are going to be admitted.*
>
> *That then means that my staff, …, are unable to deliver the standard of care they know the patients require. They are seeing people in the waiting room. We are having junior doctors assessing people in chairs, we are having people with embarrassing medical conditions waiting in a common waiting room, we are having people with mental health issues who are in a noisy, busy waiting room. Staff are forced to try to manage these people in non-clinical areas.*[122]

3.40. Dr Scott's submission spoke of the moral injury to ED staff from working under these sorts of conditions.[123] The Committee heard from many submissions, including paramedics and ED staff, who spoke about the moral injury they suffered through not being able to provide optimal care or treatment because of transfer of care delays, and witnessing the adverse health outcomes for patients.

3.41. Dr Scott describes the loss of highly experienced staff, replaced by locums and junior staff, working under transfer of care delays. He details how the reduced senior workforce in ED's has contributed to increases in transfer of care delays and patient risk:

> *Wellbeing of staff is affected on multiple fronts including the significant moral injury of not being able to provide the optimal care for patients with the rate of attrition highest among emergency department workers at the Royal Hobart Hospital compared with other departments at the RHH. As a result, Tasmanian EDs are the highest utilisers of locum doctors who [are] costing the state far more than contracted doctors would. This workforce is transient and do not retain corporate*

[120] Transcript of evidence, 14 December 2023, Health and Community Services Union, p. 20.
[121] Submission No. 36, Australian Nursing and Midwifery Federation, Tasmanian Branch, pp 4-5.
[122] Transcript of evidence, 23 January 2024, Dr Paul Scott, p. 3.
[123] Submission No. 43, Royal Hobart Hospital Emergency Department, pp. 3-4.

knowledge to enable increased efficiencies and standardised care in the medium to long-term.

Multiple junior doctors rotating out of ED increase their FTE when on external rotations but reduce it again when they return to do battle in ED. We have had an enormous efflux of senior nursing staff and senior registrars. In their place we have extremely junior staff who bring with them increased supervision burden and increased risk. This lack of senior workforce means ED is unable to process patients as efficiently, this in turn contributes to TOCDs.[124]

3.42. Dr Scott also described how increased violence to staff from transfer of care delays leads to a loss of staff:

With the public having to wait longer due to access block leading to ED overcrowding, there is increased harm due to disgruntled patients as well as increased incidence of workplace health and safety incidents due to having to treat patients in inappropriate places. Violence to staff has become an unwelcome daily companion to ED staff. This further impacts staff retention with cumulative moral, psychological and physical injury resulting in senior staff leaving the workplace.[125]

3.43 Dr Scott also spoke about the fear of legal risk that contributes to the loss of ED staff and the cascading increases in risk to patients and staff:

There is a large level of dissatisfaction and fear of medical legal consequence and significant risk. That means we have significant staff attrition, particularly in the senior workforce areas of both medical nursing, but also senior allied health professionals, clerical staff members, other people who feel that the risk in Emergency Department is so great that it's not an environment they wish to subject themselves to medical legal risk and also the dissatisfaction of delivering inappropriate patient care.

What you get instead is junior staff members who don't have the corporate knowledge. I lose a senior staff specialist of 20 years' experience. In their place I get a first-year staff specialist who is fantastic; it's taken them 17 years to get to that point. But I've lost 37 years of knowledge and in their place I have a one-year doctor who's enthusiastic and energetic and puts up with it for a fair while, but essentially it means there's a loss of corporate knowledge. There's a loss of efficiency of processing. There's increased adverse events. There's increased patient harm. There's increased patient frustration because of lack of clarity of management plan. There's increased burden on the few remaining senior staff right across the workforce, not just medical. Meaning that the supervision burden is such that people drop their hours or transfer out of emergency into another area.[126]

3.44 Mr David Pittaway, Registered Nurse and ED Navigator, in his submission, also outlined the staffing problems that have arisen due to staff no longer wishing to work under the enormous stress that they are subjected to in the ED:

I have seen many skilled experienced ED nurses staff leave the ED in my time, many because they did not want to work under such pressure anymore, or, they believe the department is unsafe and they do not want to be held legally liable for a problem not

[124] Submission No. 43, Royal Hobart Hospital Emergency Department, pp. 3 – 4.
[125] Submission No. 43, Royal Hobart Hospital Emergency Department, pp. 3-4.
[126] Transcript of evidence, 23 January 2024, Dr Paul Scott, p. 4.

of their making. There are plenty of much better paid jobs interstate which do not come with as much pressure and concern, or, they are getting out of heath care totally because of their disillusionment.

Nurses and doctors chose Emergency Department work for a variety of reasons. For nurses, a major reason is that they do not like ward nursing, just as there are many ward nurses who do not like ED nursing. With the advent of bed-block and poor patient flow, there is a lot more ward-nursing happening in the RHH ED (and I'm sure in the LGH & NWRH too) which is a real turn-off for some staff. It's not the work they want to do.[127]

3.45 Mr Pittaway noted ED staff often experience moral injury due to the substandard care and increased risk to patient safety resulting from transfer of care delays:

During times of ramping, the Navigator is constantly reminded of the TOC patients requiring better care — by doctors, CINs, AT officers and nurse managers. There are phone calls from pathology and imaging departments, telling of TOC or WR patients with results that require urgent actions, all the time assessing the needs of people not presenting by AT. There are stressed nurses telling you they have not got the time or hands to deal with the workload being imposed on them by the TOC escalation process – Tier 1 & 2. Many nurses and doctors have not had their meal breaks, and AT crews are dropping off patients with much less handover than 'normal', making staff feel unsafe and compromising patient safety. Doctors are asking for resus bays to perform comfort seeking procedures of patients who have been waiting hours to have e.g. their fractured leg put back into alignment, but the Navigator has to keep playing the board game of 'Get patients out of TOC by prematurely moving other patients out of the ED' as an imposed priority.

This is stressful and takes a toll. More often than not these events occur outside business hours when ancillary staffing is lower, the Navigator has no clinical support to keep running the department, the transit lounge is not open and there is push-back from the wards to accept rapid transfers, regardless of the Tier processes.[128]

3.46 The mental burdens suffered by health professionals were also highlighted by Rural Doctors Association Tasmania (RDAT):

Health professionals continue to experience considerable physical and mental burdens and suffer significant moral and professional injury from working in these sub-optimal conditions. They come to work to provide high quality and safe healthcare but are demoralized by providing care that is just 'enough' to get patients through, in a system that prevents them from striving for and providing 'excellent' health care.

The persistent moral injury from not being able to perform to the best of one's ability and seeing adverse outcomes for patients and colleagues has contributed to the burn out of health professionals and seen them leave for other areas of work within the health system (Urgent Care Centres for example) or leave the system altogether.[129]

3.47 Clinical burnout was also discussed by the Royal Australasian College of Physicians (RACP):

[127] Submission No. 46, Mr David Pittaway, p.8.
[128] Submission No. 46, Mr David Pittaway, p. 8.
[129] Submission No. 57, Rural Doctors Association Tasmania, p. 5.

Bed blocked patients, who are overwhelmingly on inpatient wards and in emergency departments are a particularly strong driver of clinician burn out…

Burnout is an acute problem with critical consequences. We note that Tasmanian trainees within the RACP are simultaneously engaged in postgraduate specialist medical training and work in accredited training locations throughout the state's health system, and that this often brings unique stressors and pressures. Senior specialists are often consumed with clinical duties and supervision, impeding their ability to undertake ongoing professional development and conduct research. These factors have contributed to significant burnout throughout the physician workforce, including in Tasmania.

Burnout has been fuelled by a lack of appropriate or accessible resources, workforce shortages, and increased workload. Greater challenges in the regions have led to high staff turnover and greater reliance on locum doctors.[130]

3.48 Mr Toby Rowallan, spoke to the Committee of the challenges he regularly faces in his role as an ambulance dispatcher. The significant gaps in staff on ambulance station rosters places enormous pressure on paramedics who turn up to shift. This results in paramedics working alone, lack of staff breaks and in very long waits for ambulances to respond. He describes the intense and psychologically harmful pressure of knowing priority patient call outs are waiting long periods for a response:

Mr ROWALLAN *— … 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, …, 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.

[130] Submission No. 62, Royal Australasian College of Physicians, p. 6.

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. … 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.[131]

3.49 The pressure experienced by ambulance dispatchers who are desperate to have priority calls responded to is flowing on to paramedics stuck caring for patients on the ramp. Submission 16 spoke on the pressure for paramedics on the ramp to care for multiple patients at once:

Whilst ramping in the hallway, staff were expected to care for as many patients as possible. 2 low acuity patients per qualified paramedic was the policy. However duty managers pressured and demanded that you could take more. When a paramedic worked with an intern the number of ramped patients was reduced to 1 per paramedic and intern due to the intern not being able to practice independently. Duty managers and Comms staff would demand that in these circumstances, you take 2 or more patients and often related if you didn't take them to your lack of ability as a paramedic. "Can't you handle two" etc. Or would tell other crews that you "wouldn't take their patient" resulting in them not being able to leave, and causing friction amongst workers and increasing the pressure to take another patient.[132]

[131] Transcript of evidence, 24 January 2024, Mr Toby Rowallan, pp. 2-3.
[132] Submission No. 16, Private witness, p. 3.

3.50 This paramedic also described the pressure they experience by Ambulance Tasmania's (AT's) communications' duty managers when ramped:

> *Whilst being ramped at RHH, both in the corridors and in the "ramping area" communications officers, communications duty managers and on road duty managers would call to ask; "how long will you be" "are you done yet" "can you hand over" "when can you leave" or to tell you "we have P1's waiting" "we have jobs waiting" "we need you to respond" "we don't have free crews", constantly and persistently applying pressure to the on road staff, multiple times a day, and impacting on their mental health and wellbeing.*
>
> *The constant pressure on the ramp that is applied by TAS Communications Officers, TAS Communications Duty Managers, TAS On Road Supervisors, DEM nursing staff and DEM Doctors is completely unacceptable and has significant negative impacts on the mental health of the on road staff. Not to mention that the ramp is already a breeding ground/cesspit for and of inter-ambulance conflict, negativity and poor workplace culture.*[133]
>
> *I have made safety reports about multiple situations, some of the above mentioned, that occur on the ramp. For almost all situations it was deemed that "no harm" was caused as the patient did not die or did not show any signs of harm at the time. There is no doubt that almost all of these patients received substandard care, endured prolonged recovery and had less than optimal outcomes. We either care about patients or we don't. There is no point conducting case reviews and auditing at TAS, if we offer substandard care and that is "ok" because "no one died". We either have integrity, or we don't.*[134]

3.51 Mr Matthew Carew, an ED nurse, also wrote about the stressful and unsafe environment for patients resulting from transfer of care delays, leading to people like him leaving the job they loved:

> *I worked in the LGH Emergency Department as a nurse for 12 years from 2010. I performed the duty of shift coordination for the majority of my shifts for a good portion of those years. I loved my job and the people I worked with, staff and patients. I would likely still be working in the department if it were not for the constant access block and resultant ambulance ramping that occurred, which created an overbearingly stressful and unsafe environment. It was a daily occurrence that multiple people, both in the waiting room and on the ambulance ramp, would be waiting for unacceptably long times for access to a bedspace. I had worked 10 hours shifts where the same patients were ramped from before I arrived to after I had handed over and gone home because the department was completely gridlocked. These were often very sick people whose conditions would greatly benefit from a bedspace to be made comfortable and to be appropriately monitored and provided with medical and nursing care. There was the constant risk that the ambulance crew looking after the patients would be forced away to a priority job and leave the patient on the ramp with minimal capacity for ED staff to take over and provide appropriate care. The few bed spaces that would be made available during a shift would have to go to the highest priority patient in clinical need and should not be influenced by mode of arrival. However, constant ramping and the flow on effect to the community made these decisions very difficult to make.*[135]

[133] Submission No. 16, Private witness, p. 4.
[134] Submission No. 16, Private witness, p. 4.
[135] Submission No. 33, Mr Matthew Carew, p. 1.

3.52 Mr Mulholland, a retired intensive care paramedic outlined issues problems with paramedics losing breaks when ramped at the hospital:

> *Missed or late meals are frequent when ramping. … a type 1 diabetic and found it increasingly difficult to continue long-term due to the unpredictable nature of meal times and hydration. … the growth of ramping has made the situation more difficult.*[136]

3.53 Submission 16 also spoke of the difficulties faced by paramedics who are ramped not getting sufficient breaks:

> *Whilst in the ramping area it is an expectation that you can go and get your lunch there and have a break, at times Communications staff will see that as your allotted break, or perceive that you have had a sufficient rest.*[137]

3.54 Submission 37 outlined how transfer of care delays force paramedics, trained as emergency responders, to perform duties outside of their job, including the work of orderlies, nurses and ward aides:

> *When patients are ramped with us, there is an expectation from the hospital staff that we will look after their every need which includes jobs that are completely out of our job description and training (e.g transferring patients around the emergency department in hospital beds, cleaning up after our patients if they make a mess, toileting the patients etc.). In fact, it's not just that there is an expectation to perform these duties, but there is often a necessity to do so. For example, if I am stuck with a patient on the ramp for several hours, and they are unable to walk or have poor mobility, and they suddenly need to use the toilet, that is now my problem to deal with. I would be well within my rights to call for a nurse to come and toilet the patient for us, but when the emergency department is busy (which is most of the time), the nurses seldom have the time to come and assist us as they are already overwhelmed by the demands of their job. It is also something that I, and I'm sure many of my colleagues, do not feel comfortable doing as it feels like passing the buck and has the potential to cause tension between us and the nurses. Furthermore, if there are multiple patients on the ramp, some of them will inevitably have to be neglected if we are required to toilet another. This poses risks to both patient safety and our own registrations as we are ultimately the ones responsible for their care while they are on the ramp. We are paramedics. We are trained to drive around in ambulances and provide pre-hospital emergency care to patients. We are not orderlies. We are not ward aides. We are not nurses. Sadly, however, we are required to act as all 3 at times when we are on the ramp.*[138]

3.55 The pressure of transfer of care delays strains relationships between paramedics and hospital staff. This relationship has historically been positive and collaborative, but many witnesses talked about the tensions and competitions that have developed between these two staff cohorts recently. This was something discussed by Ms Jess Brennan, former LGH nurse:

> *I often work as the Triage nurse on a shift, and having to ramp these poor paramedics almost every day is taking its toll on everyone. I believe we have a great working relationship with AT, but I have seen that become strained over the past few years as*

[136] Submission No. 35, Mr Peter Mulholland, p. 1.
[137] Submission No. 16, Private witness, p.3.
[138] Submission No. 37, Private witness, pp. 1-2.

ramping and workload has rapidly increased. I also believe Primary Healthcare in Tasmania is a big problem, with many people unable to get into GP's. As a Triage Nurse I see a lot of people call an Ambulance for non emergency reasons or non life threatening illnesses, taking critical ambulances off the road, as they cannot get into a GP and believe they will get into the ED quicker and be seen quicker, which is not the case. The ANUM or In Charge Nurse of the shift have regular ED Huddles with the Doctor in Charge and AT when ramping is greater than 30 minutes (every day), but hardly anything comes of these huddles because of the bed block there is just no where to move. I sincerely hope something will come of this Parliamentary Inquiry, as everyone at the LGH is exhausted. We have lost so many senior staff, including Paramedics, Nurses and Doctors due to the workload, bed block and ramping, that it is becoming near impossible to turn up to work every day. I had the privilege of working in Queensland last year to have a bit of a break, and working in large hospitals with almost no ambulance ramping and beautiful bed flow was amazing. I hope that one day the Tasmanian Health Care System can have that reprieve from the relentless work we do every single day.[139]

3.56 Submission 37 also spoke of the conflict caused from transfer of care delays between ambulance and Emergency Department staff:

Ramping causes unnecessary conflict and tension between ambulance and emergency department staff. Although I believe it is unreasonable for emergency department staff to direct their frustrations of the healthcare system towards us directly, I can understand how it occurs. When we are ramped, we are occupying space in their work environment, and at times utilising their resources. During busy periods there could be upwards of 10 paramedic crews and patients occupying the hallways and ramping area of the emergency department. The ED staff are almost always busy and struggling to keep up with the workload, without having to worry about being held up in the hallway because there are paramedics in the way transferring their patient from an ambulance stretcher to a hospital bed for example. On one occasion I went to retrieve a wheelchair for my patient who couldn't ambulate very well as the treating doctor was happy to transfer them from the ramp to the waiting room. This was a particularly busy day in the hospital, and I couldn't find a wheelchair around the emergency department. I eventually located one in the room where the orderlies reside, and as I went to retrieve it an orderly got up out of their chair and confronted me about taking the wheelchair. They questioned me as to why my patient needed the wheelchair and said, in quite a hostile manner, that they wanted to keep the wheelchair where it was in case they needed it in future. I explained to the orderly that my patient couldn't walk very well, and that I needed the chair to assist them into the waiting room. I could have reminded the orderly in that moment that I was actually doing their job for them and, if anything, they should be thanking me, but I decided against it as I felt it would be a pointless exercise. Once I returned to the ramp to assist my patient I turned around and realised the orderly had actually followed me back to the ramp, presumably to confirm that my patient's condition did in fact warrant a wheelchair and that I was being genuine. This is just one example of many instances where I have been made to feel by other staff in the emergency department like we are simply a hindrance to them.[140]

3.57 Submission 37 provides an example of the experience many paramedics described occurring on a daily basis. Paramedics on the ramp are often exposed

[139] Submission No. 15, Ms Jess Brennan, p. 2.
[140] Submission No. 37, Private witness, pp. 2-3.

to professional and legal risk, as well as unbearable stress, verbal abuse and the risk of violence, while trying to care for patients:

> *We are isolated on the ramp. Because the Emergency Medical Unit is a separate area to the ED, if we have an emergency we are often on our own. On one occasion I was looking after 3 patients on the ramp, one of whom was a young, ill-tempered and hostile man in their 20s with a criminal history who was ostensibly drug-seeking. The paramedics that brought him in had in fact given him some morphine as he was complaining of chest pain, despite the fact that he had been investigated through cardiology already with all findings demonstrating there were no cardiac issues whatsoever. The triage nurse had indicated that once a blood test/ECG had been conducted on the ramp and signed off by the treating doctor, he could potentially be offloaded from the ramp and into the waiting room. I had hoped that because he had been recently given pain-relief, he would be content until the ECG/blood-test had been performed. Unfortunately, as is often the case, the emergency department was very busy and nobody came to complete the tests, and I was unable to as I was monitoring my other 2 patients.*
>
> *Half an hour or so passed and this patient became disgruntled and started to demand more pain relief from me. I told him I wasn't able to give him any but assured him I would call for a nurse to come up, which I did.*
>
> *Another 10 minutes or so passed, and still no one came. The patient then started to become verbally abusive, shouting and swearing that he was in pain and needed more pain-relief. He then started to call the Emergency Department phone number and verbally abused the ward clerks when they answered. I didn't actually realise this until one of the ward clerks called me on the internal phone on the ramp to inform me what had happened, and insinuated this was a problem they were expecting me to fix. I called a nurse again to explain what was happening and asked if someone could please come and do the blood test/ECG so that a doctor could sign off on them and we could get this patient off the ramp and into the waiting room. Still no one came. He was becoming more and more agitated and I was beginning to feel unsafe so I decided to leave the ramp to find the Clinical Coordinator and explain what was happening and that I needed help. This of course meant I had to neglect my other 2 patients and leave them unattended during that time which posed a risk to their safety and also my registration as, if anything adverse happened to them, I would have been held responsible. Unfortunately, in that moment, I felt I had no other choice. The Clinical Coordinator then assigned a nurse to return to the ramp with me to perform the blood test/ECG, and also administer a NSAID for additional pain relief. Once that was completed the nurse took the ECG/blood test results straight to the treating doctor and afterwards I was informed the patient could be offloaded into the waiting room. I approached the patient and explained to them what was happening, and that I would escort them to the waiting room.*
>
> *So once again, I had to temporarily neglect my other 2 patients while I escorted them out of the ramp and, while walking him out to the waiting room, he verbally abused me again as he felt he was being unfairly treated. Upon reflection of that experience, I can't help but think — what if he escalated even further and became physically aggressive towards me? No one would have been there to help.*[141]

3.58 The extreme transfer of care delays, combined with the increased numbers of people on the ramp, have resulted in ramped patients being placed in medically inappropriate locations in ED's. This situation has a harmful impact on

[141] Submission No. 37, Private witness, p. 3.

paramedics, who are forced to work outside their scope of practice, and on the patients, they care for.

Dr Scott spoke of the difficulties for staff acting outside their scope of practice:

> ***CHAIR*** *— On top of that, there is the extra, and relatively recent in the history of the Emergency Department burden of ED staff having to manage patients who are on the ramp, who are unable to be given the proper care they need by paramedics because it's outside their scope of practice. There's a physical distance and a whole extra area and complication of working to patients who are on the ramp.*
>
> ***Dr SCOTT*** *— Correct. There is a difficult interplay in non-clinical area utilisation. Launceston General Hospital, for example, has patients in corridors for greater than 24 hours. They've accessed an old cupboard and removed the shelves and had patients in a cupboard. They've used airlock areas. We use essentially non-clinical areas that are going to be utilised with the rebuild shortly for the bulk of our ramp patients. The sicker patients we keep in the corridor next to our resus area. That then has problems with fire access, egress, congestion corridors, lack of privacy, and lack of a proper place to assess people.*
>
> *The paramedics do a fantastic job looking after their patients within their scope of practice. However, many patients need extended scope to keep them safe. These are the most vulnerable patients in the entire system: patients who are in the community and are yet to be resourced by an ambulance.*
>
> *The next most vulnerable subset are patients who are on the ramp and are yet to be properly accessed. From the medical side of things, they've been managed up to the limit of the scope of practice from an ambulance perspective, but these people may need different antibiotics the paramedics can't give. They may need special types of procedures, other things that medical can give and paramedics can't.*
>
> *Then the next most vulnerable are the patients who have been seen on the ramp by a medical team but are in a non-appropriate location, which is not a clinical space and that might be the ramp. We have a frail, elderly, delirious patient who might be on a ramp from 12 to 14 hours, no natural light, noisy, lights on 24 hours, hustle and bustle, toilets nearby but far from ideal and a real dichotomy of what that same patient would get if they were physically located on the ward where they would have a proper day-night cycle, older person-friendly environment in terms of minimising falls' risk and delirium, and more rigorous attention from a nursing staff perspective for ongoing management of care. That may be a strange thing to say.*[142]

3.59 Multiple paramedics provided evidence to the Committee of their distress at being unable to assist patients with necessary treatments on the ramp, because of legal prohibitions to working outside their scope of care. They gave examples of patients deteriorating or suffering adverse outcomes when appropriate treatment was not able to be provided. Submission 37 wrote of the serious ethical dilemmas and mental health impacts faced by paramedics:

> *Doctors will often try to commence treatment on ramped patients with medications that we are not permitted to give. Of course, in a lot of cases, this can be beneficial for the patient, however there are inherent risks associated with it to both the patient*

[142] Transcript of evidence, 23 January 2024, Dr Paul Scott, pp. 4-5.

and ourselves. For example, a doctor might wish to commence antibiotic treatment on a ramped patient to treat sepsis as a delay in treatment could ultimately result in serious morbidity or even mortality. However, the administration of these antibiotics is not something which falls under our scope of practice as paramedics, and they can precipitate severe allergic reactions which could also result in serious morbidity/mortality. This presents a serious and unfair ethical dilemma to us whereby we are forced to make a decision which could potentially jeopardise the health outcome of our patient or our own registration and ultimately our career. One of my colleagues had this exact experience not long ago, and they refused to let the doctor commence treatment with antibiotics due to the associated risks. The nurse who was tasked with administering the antibiotics then told my colleague that if the patient deteriorated it would be their fault. It is completely unacceptable and wrong that we should ever be personally blamed for the failures of our healthcare system.

In contrast, another one of my colleagues allowed a doctor to commence antibiotic treatment on their patient who was profoundly septic as they were concerned about their risk of deteriorating. This patient ended up having an anaphylactic reaction to the antibiotics and, in spite of this, they still remained on the ramp. Patients with life-threatening illnesses who present to the emergency department should never be ramped in the first place, and the fact that our hospital often lacks the resources to provide the necessary care to such patients is a truly damning indictment of our healthcare system as a whole.[143]

3.60 Submission 16 outlined the lack of dignity many patients suffer who are ramped, including even in extreme situations where patients have died without privacy and family:

Attended a case of female with recent diagnosis of … liver cancer, pre-COVID. I was working with a UTAS student, as a single officer (this was also against the policy at the time). This patient was unwell and required assistance to extricate from her house, back-up was sent from the ramp. On arrival at DEM, this patient was ramped along the back corridor near the staff toilets. Whilst being ramped it became apparent that the patient had entered the actively dying phase. I liaised with hospital staff and triage multiple times over the hours of being ramped. Each time with fear, as I was forced to leave the patient in the care of a UTAS student, whilst seeking a more appropriate care option. The patients daughter and husband were in the waiting room but not allowed to sit with her due to ramping restrictions.

Eventually this patient was moved to a room for the last minutes/hour of her life. Psychologically this impacted me negatively as this patient was not afforded the opportunity and comfort of having her family present with her during those hours, not to mention robbing the family of the time and above all else the inability to care for her sufficiently and in a safe and private environment – no basic level of dignity.[144]

3.61 Poor workforce management by Ambulance Tasmania (AT) in response to excessive ambulance ramping has resulted in fewer staff presenting for shifts, and extra pressure on understaffed crews:

Ramping nightshift crews and holding them over occurred regularly, as regularly as almost every shift. The policy was that ramped nightshift crews were to be relieved by

[143] Submission No.37, Private witness, p. 2.
[144] Submission No. 16, Private witness, p. 1.

the first available crew – pending a priority 1 case or a priority 0 (cardiac arrest). It was the norm that the nightshift crew would be held over until a day shift crew arrived at the hospital, after attending a case, with their own patient, and then once they were triaged and ramped, they would relieve a nightshift crew. Zero attempt was made by Communications Duty Manager to relieve the ramped nightshift crews, when calling to ask what their plan was it was inevitable that they would refuse a crew for relief and were not proactive about relieving the crews as per the policy – this would cause the nightshift crews into forced overtime and push out a 14 or 12 hour shift into a 17, 16 or 14 hour shift, and then the crew would need to return to their station and unpack and then drive home fatigued. This in turn increased the amount of staff calling in sick for the second night shift due to being fatigued and generally unsupported.[145]

3.62 In a public hearing, the Chief Executive of Ambulance Tasmania, Mr Jordon Emery, was questioned in relation to the mental health and wellbeing of his staff:

CHAIR *— Mr Emery, in 2021 Ambulance Tasmania arranged for an organisation called Frontline Mind to survey the workforce to assess their general mental health and wellbeing. I am sure you would agree, as your predecessor did, that the results of that survey were deeply disturbing. With this scan now three years old, and ambulance ramping and other workforce pressures now far worse than that time, have you conducted another scan of workforce mental health and wellbeing?*

Mr EMERY *— The short answer, Dr Woodruff, is no. In October we permanently appointed a senior manager of culture and wellbeing, who sits on the executive of Ambulance Tasmania. She is doing a body of work on identifying how we can continue to report and monitor culture. I am not suggesting that the appointment of a single position is the solution here, but we certainly received at least anecdotal feedback about the Frontline Mind, or the resilience scan approach, and we have also received feedback that shorter whole surveys around organisational culture will be more effective at giving us more timely indications, as opposed to surveys done on a yearly basis. We are working on more regular and more frequent surveying of staff around their experience of workplace culture at present, and of course Ambulance Tasmania also participates in the Tasmanian State Service employee survey as well.*

CHAIR *— Sure, maybe once a year is not often enough, but you have not done one for three years. When is the next one going to be?*

Mr EMERY *— No, the last survey was completed in the middle of 2022.*

CHAIR *— What did that say?*

Mr EMERY *— It showed an improvement of about 15 percent in the net promoter score, but of course there were still concerning trends in that around organisational culture. If I can take you back to your comment, if employees still describe feeling a sense of threat, that is a problem that sits firmly on me to address.*[146]

[145] Submission No. 16, Private witness, pp. 3-4.
[146] Transcript of evidence, 5 February 2024, Ambulance Tasmania, pp. 9-10.

3.63 In light of a Coroner's report regarding the death of a paramedic, Mr Emery discussed Ambulance Tasmania's ongoing response to the report and the current psychological supports available for paramedics:

> ***CHAIR*** *— In the Coroner's report on the death of an Ambulance Tasmania paramedic, Mr Damian Crump, there was a recommendation made for mandatory regular psychological assessments of staff. This inquiry has heard the very serious impact of ambulance ramping and the psychological damage being caused to staff, and people leaving because of it. One person who gave evidence said, 'This is how you break people'. Has Ambulance Tasmania accepted this recommendation for mandatory assessments? And, if so, what's the implementation timeline?*
>
> ***Mr EMERY*** *— I think it is fair to say we are still assessing that recommendation, because there are conflicting bodies of evidence around mandatorily subjecting individuals to psychological assessments. I am concerned about what the professional or career implications of that might mean for an individual. We would really like to understand other ways in which we continue to support people through our wellbeing support that might not dictate that they must attend a psychological assessment.*
>
> *In relation to psychological wellbeing, we do have a regular wellbeing meeting, and we regularly report on employee wellbeing at the Ambulance Tasmania executive committee, which is the peak governance committee of Ambulance Tasmania, including incidents of care for individuals who are engaging with our wellbeing support team. Of course, it doesn't capture all of the concerns you raise but we use that data to try and understand the extent to which our supports are adequately assisting people, and where there are opportunities to improve the types of care we provide.*[147]

3.64 In their submission to the Committee, Dr Jane Tolman, Ms Jeanette Palmer, Dr Stuart Walker and Dr Virginia Watson noted hospital staff morale is negatively impacted by a lack of transparency in systems and governance:

> [The wellbeing of healthcare staff] *… is very poor… there is a system-wide failure both at the site of the major hospital (RHH) specifically, and the health care system more generally to ensure the implementation of functional processes that are transparent, accountable to all stakeholders, and which are patient-centred. The failure to implement transparent systems and procedures as well as the absence of a clear system of governance (the RHH has no independent governing board, for example) has seriously undermined staff morale and trust in hospital management.*
>
> *Most hospital staff seriously seem to think that the problems relate to inadequate staff numbers. We maintain that the reason is poor hospital culture which seeks to address the needs and wants of staff (frequent changes in treating team, lack of consultation with families and nursing home, lack of follow-up) and not the needs of the patients and their families. Change-agents are not always welcome on hospital staff.*[148]

[147] Transcript of evidence, 5 February 2024, Ambulance Tasmania, p. 11.
[148] Submission No. 48, Dr Stuart Watson, Dr Virginia Walker, Dr Jane Tolman and Ms Jeanette Palmer, p. 3-4.

FINDINGS

The Committee finds:

60. The ambulance ramping experienced in Tasmania's hospitals, has directly and seriously impacted the mental health and wellbeing of many emergency healthcare staff.

61. Ambulance Tasmania staff have experienced extreme emotional pressure, mental health impacts, and moral injury through:

- being forced to choose between following their scope of practice or allowing patients to access necessary medical care;
- being stuck on the ramp and not being able to work in their role as emergency responders in the community;
- being forced to care for multiple patients at a time on the ramp due to the requirement for other crews to respond to emergency calls, or pressure from within Ambulance Tasmania management;
- hearing Priority 0 and Priority 1 triple zero calls remaining unanswered for long periods;
- experiencing extreme pressure and stress when trying to manage and dispatch ambulance resources;
- attending ambulance callouts as a sole paramedic without necessary support;
- receiving verbal abuse and the risk of violence from patients;
- working without meal breaks and forced overtime; and
- working under increased fatigue and the associated personal and patient risks.

62. Tasmanian Health Service staff in Emergency Departments have experienced extreme emotional pressure, mental health impacts, and moral injury through the increased workload and workplace conditions associated with transfer of care delays.

63. As a consequence of negative workplace impacts from ambulance ramping, many Ambulance Tasmania and Tasmanian Health Service staff in Emergency Departments have suffered stress, anxiety, depression, post-traumatic stress disorder and burnout. This has resulted in:

- increased sick leave and worker's compensation claims;
- staff reducing hours to cope; and
- staff leaving Ambulance Tasmania and the Tasmanian Health Service because they are no longer able, or willing, to work in emergency healthcare.

64. The impact of extensive ambulance ramping has resulted in Emergency Departments and Ambulance Tasmania losing senior skilled staff, and a loss of corporate knowledge and experience.

65. Longer transfer of care delays are causing conflict between ambulance and Emergency Department staff around the provision of optimal care for patients, in what has historically been a collaborative work environment.

66. Paramedics regularly feel pressure from Ambulance Tasmania or Emergency Department staff to perform tasks outside of their scope of practice, and duties, while they are on the ramp.

67. Ambulance Tasmania and Tasmanian Health Service staff currently do not have sufficient psychological supports in the workplace.

IMPACT ON EMERGENCY DEPARTMENT AND OTHER HOSPITAL FUNCTIONS

3.65 Transfer of care delays also impact the ED and other hospital functions. The Health and Community Services Union (HACSU) noted a number of these, including strain on ED resources, ED overcrowding, resource allocation and patient flow.[149]

3.66 The Australian Nursing and Midwifery Federation (ANMF) Tasmania Branch noted:

> *EDs and hospitals experience severe strain due to transfer of care delays, affecting the overall efficiency of healthcare services and the ability to provide timely care to all patients. This means that ED patients wait too long to be seen and potentially deteriorate during that time. It means patients wait in an environment in ED which is not an environment conducive to health improvement and often are then sicker when admitted. Then, when reaching a ward/unit, patients are moved quickly through an admission to discharge, often sooner than our members would like due to the pressure to create more bed availability.*[150]

3.67 Dr Paul Scott, Acting Director, also noted the impacts of transfer of care delays throughout the Royal Hobart Hospital (RHH) ED, with patients outnumbering bed capacity, increased nurse to patient ratios and lack of appropriate clinical spaces:

> *Although there are set limits of how many patients are allowed on each ward, this is no 'cap' for patients requiring care in the ED. Once all the ED beds are full, they overflow into the waiting room or remain with ambulance staff creating TOCDs. Waiting room patients are cared for by ED staff with unsafe nurse-to-patient ratios. Lack of privacy and a reduced ability to observe and care for patients impacts the quality of care the Tasmania public receive.*
>
> *The lack of appropriate spaces to see patients leads to increased adverse events, longer hospital stays and increased morbidity and mortality.*
>
> *The RHH is the only public hospital in Southern Tasmania. Calvary regularly shuts its ED on weekends and Hobart Private Hospital has greatly reduced hospital capacity over holiday periods. The RHH, cannot go on bypass (as occurs with mainland public*

[149] Submission No. 53, Health and Community Services Union, pp. 10-11.
[150] Submission No. 36, Australian Nursing and Midwifery Federation, Tasmanian Branch, p 5.

hospitals), we simple absorb the increased attendances (both via ambulance and walk ins).[151]

3.68 The Australasian College of Paramedicine (ACP) described how transfer of care delays negatively impacts on the quality-of-care staff are able to provide in a pressured environment:

> *… Staff have an increased risk of exposure to error and pressure to meet four-hour turnover, which has led to symptom treatment rather than core issue treatment. Longer offload times are associated with a greater risk of death and ambulance re-attendance within 30 days.*[152] [153]

3.69 Mr David Pittaway, ED Navigator at the RHH ED, spoke of how transfer of care delays dramatically increases the workload of ED staff, and changes the optimal flow of work within the ED:

> *TOC patients increase work for all ED staff, without getting a corresponding staffing ratio increase. If AT cannot provide a TOC crew, and TOC patients are accruing, AT crews in the TOC area will take over care of departing crews, so more ED staff resources get redirected to the TOC area for whatever length of time. This often means walking to & fro from the TOC to the ED, and again, and again. It's time consuming and is time away from ED other patients.*
>
> *Tier 1 & 2 responses, when TOC transfers are prioritised to allow faster return of crews back on the road, are significant interruptions to basic ED functioning.*
> *While the ED is supposed to keep functioning, that is, patients randomly attending the ED by whatever means, and ED staff attending the patients already inside and needing care, a major patient transfer event is supposed to happen simultaneously, with orderlies and Clinical resource nurses from the main hospital supposedly being re-directed to assist in the ED. In reality, this support is rarely found, generally due to inpatient MET calls, out of hours CT and MRI assists, Code Blues and Code Blacks, and staff absences, so ED patient care suffers and ED staff suffer.*[154]

3.70 Dr Jane Tolman, Ms Jeanette Palmer, Dr Stuart Walker and Dr Virgina Watson spoke in their submission of the lack of patient-centred care in the ED, particularly for people with ageing-related conditions:

> *… the ED and hospital functions lack coordination, transparency and any semblance of good governance based on a best practice model of patient-centred care. Further to this, the hospital currently operates on a general medicine model of care for almost all medical (as opposed to surgical) patients. This is inappropriate for patients in the number 2 category of cause of illness and death in Tasmania and Australia-wide namely, those diseases associated with ageing- the neurodegenerative conditions including dementia (90%) but also Parkinsons, motor neurone disease and so on.*[155]

3.71 Ms Jess Brennan outlined how numerous non-clinical spaces at the Launceston General Hospital (LGH) have been adapted to accommodate ramped patients

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[151] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 4.
[152] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022, referenced in Submission No. 54, Australasian College of Paramedicine, pp. 5 -6, footnote 37.
[153] Submission No. 54, Australasian College of Paramedicine, pp. 5 -6.
154 Submission 46, Mr David Pittaway, pp. 9-10.
[155] Submission No. 48, Dr Stuart Walker, Dr Virginia Watson, Dr Jane Tolman, and Ms Jeanette Palmer, p. 4.

and the problems associated with these treating patients in these inappropriate conditions:

> *An area which was used for storage of equipment and linen was redeveloped into a three bed ramping space, this area is known as Bed 33/AT 33 Wait. It is tucked around the back of ED near the short stay Emergency Medical Unit. Two of the beds have cardiac monitors, and one is simply what we all call the "broom cupboard" as it is a tiny space that only just fits a bed. This area is completely unsafe as there is not enough room for the paramedics to sit and monitor their ramped patients, there is one suction unit and two oxygen supplies and an inadequate amount of emergency buttons should something go wrong, which happens on a regular basis. To accomodate [sic] this area, a nursing position called "33 Offload" was created. This nurse assists the ramped paramedics with their patients if needed, and when the paramedics get called to a Priority 1 or 0 call, they need to "offload" their patients to this nurse so they can attend the job. This nurse legally should only be left with a maximum of 4 patients to meet the 1:4 ratio, however this is often not the case and they can be left with up to 5 unwell patients.*
>
> *The "Airlock" area is also used for ramping and is at the ambulance entrance to the ED. This area can fit up to 4 ramped patients, and also often has people ramped in chairs and wheelchairs. The Airlock does not have any suction, oxygen or monitoring, nor does it have any emergency buttons, making it what I believe to be the most dangerous place in the ED. An "Airlock Offload" nursing position was also created in the last few years for this area. Ramping extends up the corridors on a daily basis as Bed 33 and the Airlock become full, which is not only inappropriate for patients receiving care, but creating unsafe workspaces and blocking important thoroughfares.*[156]

3.72 The Rural Doctors Association Tasmania (RDAT) suggested that there be another area within the hospital other than the ED that can also deal with acute patients:

> *A significant number of patients are referred or transferred to the Emergency Department as it is only space within the hospital that can provide care for the undifferentiated and acutely unwell patient. RDAT recommends that the Committee should examine whether there are other areas within the hospital that can be appropriately resourced to bypass Emergency Departments and provide acute care to patients from the community and/or on referral from GPs e.g. Acute Medical Units, Acute Surgical Units.*[157]

FINDINGS

The Committee finds:

68. Ambulance ramping has a significant negative impact on the workload of Emergency Department staff.

69. Ambulance ramping at times, interrupts the normal workflow and triaging system of the Emergency Department.

[156] Submission No. 15, Ms Jess Brennan, pp. 1-2.
[157] Submission No. 57, Rural Doctors Association Tasmanian, p. 6.

70. Transfer of care delays add additional pressures on Emergency Department clinicians and the quality of care they are able to provide patients. Older people, and people with neurodegenerative conditions, are especially impacted.

71. When access block occurs in a hospital, ambulance ramping results in more patients needing a bed in the Emergency Department. This is not a desirable situation, for the health of the patients or the functioning of the Emergency Department.

72. The use of clinically inappropriate spaces to manage increased ambulance ramping demand, has resulted in increased risk of adverse health outcomes for patients.

73. Ambulance ramping has resulted in ramped patients and Emergency Department patients being subjected to unsafe nurse and paramedic to patient ratios.

74. Ambulance ramping has whole-of-hospital impacts, including via:

    a. The condition of ramped patients deteriorating, increasing demand for hospital care;

    b. The expectation that patients on wards are moved more quickly from admission to discharge to make more beds available, adding pressure to staff;

    c. Cancellations of scheduled procedures to create more bed space for ramped patients; and

    d. The allocation of hospital resources towards managing ambulance ramping, diverting resources from other parts of the hospital.

RECOMMENDATIONS

The Committee recommends the State Government:

11. Commit to increasing Emergency Department staffing to levels theat ensure safe and reliable care of patients.

12. Commit to increasing Ambulance Tasmania staffing to ensure ambulances reliably respond to incidents within safe timeframes.

13. Undertake — or collaborate with another party to undertake — a population-level assessment of the preventable harm caused to patients due to transfer of care delays and longer ambulance response times.

14. Expand the operating hours of the Ambulance Tasmania secondary triage service.

15. Review, in consultation with staff, current protocols governing clinical management of patients subject to transfer of care delays, and their use in practice. Implement changes to improve outcomes for patients and staff.

16. Support the Department of Health to undertake — in consultation with key stakeholders — an assessment of human resources employment including, but not limited to, contract type, retention, recruitment, pay scales, rostering, breaks and entitlements.

4. DATA COLLECTION AND REPORTING

4.1. The third term of reference for this Inquiry related to the adequacy of the State Government's data collection and reporting of transfer of care delays.

4.2. The Health and Community Services Union (HACSU) noted several challenges with data collection and reporting, including variability in definitions, incomplete records, a lack of real time data and data silos.[158]

4.3. The Department of Health (DoH) submission indicated that reporting of data in relation to transfer of care is a part of its service plan key performance indicators (KPIs):

> *Improving access and patient flow across Tasmania's health system is a strategic priority under the Tasmanian Health Service Annual Service Plan 2023-24 (the Service Plan). The Service Plan includes 30 Key Performance Indicators (KPIs) and targets under this strategic priority, with specific Ambulance Transfer of Care targets including 100 percent targets for the following KPIs:*
>
> *• 'Ambulance patient transfer of care – proportion occurring within 30 minutes', and*
>
> *• 'Ambulance vehicles return to on road services – proportion occurring within one hour of arrival'.*
>
> *From 2024-25 onward, the two measures above will be reported in the DoH Annual Report. The Service Plan also includes a range of other targets relating to ED transfers and waiting times, access to inpatient beds, and non-admitted patients, to help drive improvements to patient access and flow through hospitals.*[159]

4.4. The Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch noted the importance of accurate and available data to assist with management of transfer of care delays:

> *There is a pressing need to assess the adequacy of data collection and reporting mechanisms related to transfer of care delays. Comprehensive and transparent data are essential to understanding the scale of the problem and moreover devising effective solutions. Reporting the same woeful transfer of care delays as well as the wait times in EDs with no definite response is frankly negligent.*[160]

4.5. Rural Doctors Association Tasmania (RDAT) noted that the data reporting is particularly poor in the case of ambulance response times in rural and remote communities:

> *RDAT believes that the data reporting on ambulance response times and transfers is inadequate for rural settings. Current metrics make it unclear if the median emergency response time includes rural and remote responses or just urban areas. The data would suggest that rural areas have been excluded as feedback from members and their communities is they can wait hours for an ambulance in a rural and remote location. RDAT suggests that the Department of Health dashboard includes rural and remote Ambulance response times.*

[158] Submission No. 53, Health and Community Services Union, p. 11.
[159] Submission No. 64, Department of Health, p. 14.
[160] Submission No. 36, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 5.

On the ground clinicians report that they are unable to ascertain from Ambulance Tasmania approximate transfer times for rural Emergency Department patients and no clear order of priority for their patient. This creates uncertainty about how the situation is being managed and how long the local rural health service will need to care for the patient prior to transfer. Rural doctors also hold a significant burden of decision making in asking for an ambulance transfer as they know it removes the local ambulance and crew from the community, leaving a community-based emergency uncovered. RDAT suggests that clear communication is developed so that local clinicians are aware of their status in the priority que for transfer and when assets have been allocated with an expected time of arrival.

Similarly in the major Emergency Departments there is difficulty in planning for a surge of ambulance arrivals to an Emergency Department and patient flow resources should be allocated to planning for patients' arrival into the Emergency Department (and hence the need for movement within in the Emergency Department) prior to their arrival to prevent transfer of care delays. Having a critically unwell patient arrive without the appropriate clinical space can be avoided if there was enough clear communication between Ambulance Tasmania and the hospital (not just the Emergency Department) to ensure that flow through the Emergency Department and the hospital allowed a smooth transfer of care.[161]

4.6. HACSU representatives outlined issues, and provided options for data collection:

CHAIR *— … We are hearing there is a range of different systems that could be in use for patients as they move their way through the health system… what effect does that have, the fact that there are multiple different systems?*

Ms HAIGH — *When you have multiple systems nothing necessarily lines up and I think that you can have lots of errors in data if you are not using the same system. Every system will be recording — they'd make the same things but really, they are probably different and they're looking at different data sets and different parameters. I don't think you can get really any consistent and statistically significant data when it's all recorded differently in different systems.*

CHAIR *— I take it from that, you don't think's [it's] possible to get a clear picture of a patient's journey through the system. For instance, where they wait, for how long they wait, who is managing their care and any degradation or deterioration of care?*

Mr DIGNEY *— Even the definition of 'ramping' itself, Chair. You are officially not ramped until the triage nurse tells you that you are delayed and you are still charged with the care of this patient. So, you might wait up to half an hour to get that decision from the triage nurse. Ultimately, there are hours and hours in a day of ambulances waiting in an emergency department with a patient who is not recorded as ramping. You are not officially ramped until they tell you, 'We are not going to take the patient', and sometimes that may well be half an hour.*[162]

4.7. In their joint submission to the Committee, Dr Jane Tolman, Ms Jeanette Palmer, Dr Stuart Walker and Dr Virginia Watson, pointed to inadequacies with data systems in the Tasmanian Health Service:

[161] Submission No. 57, Rural Doctors Association Tasmanian, pp. 6-7.
[162] Transcript of evidence, 14 December 2023, Health and Community Services Union, p. 27.

If data collection and reporting is taking place, then the system and processes used for this are entirely opaque. The online systems, Best Med and EMR are currently not coordinated and not accessible by staff outside the hospital system (ie, in the community sector), and yet effective access and coordination of these systems across the Tasmanian health system is critical to any resolution of transfer of care delays and ambulance ramping.

We argue that the role of the Integrated Operation Centres which currently enable patients requiring acute hospital care to be transferred around the State be expanded. If expanded, the IOCs could also play a crucial role in facilitating intermediate care for complex geriatric patients. These centres could become clearinghouses for patient flow and capacity data across all non-acute care settings including, nursing homes, residential care facilities, district hospitals, Hospital in the Home (HITH) services. Best Med and an integrated EMR system could therefore play a critical role in the operations
of the IOCs to ensure timely flow of patients with appropriate medication from hospital to their subacute care setting. Currently, the inaccuracy of data on bed availability in the state's hospitals and nursing homes is a major source of transfer of care delays, ambulance ramping, patient suffering and bed-block. The relevant IT systems need immediate and effective upgrading.

The RHH geriatric team and the IOcs should establish a system and procedure for flow of patient date/ information and discharge planning.[163]

4.8. Dr Paul Scott, Acting Director of the Royal Hobart Hospital Emergency Department outlined the issues in data collection given many of the data systems utilised in the DoH are unable to 'talk' to each other:

Firstly, it is important to understand that existing data systems interact poorly with each other. The Ambulance ESCAD system does not talk to ED Trak or Patient flow systems (e.g. Simon). Attempts to rectify this previously have failed as ambulance identifies by case number ED identify by patient details. These systems therefor cannot cleanly auto populate each other. The workaround is to have an ambulance hospital dashboard available to ED staff, but this is rarely referenced as triage and ED navigator staff need to look at a multitude of data inform systems (Trak, iPM, Med tasker, Simon). In addition, the hospital dashboard shows no clear input data, i.e. it does not indicate Ambulance arrivals by time (or category). In an ideal world the ambulance feed would:

o Talk to Trak and auto populate pre arrival information

o Display an arrivals/20 min display (i.e. we may get 5 sick patients from ambulance all at the same time and none for another hour), creating capacity to offload and start definitive treatment for these patient takes time because the ED is full almost all the time.

o If ambulance, ED and patient flow systems communicated well, a real time status would be visible to the integrated operations centre who allocate beds.

o Even more ambitiously we should use data which pre-empts arrivals not only on an hourly basis but over a multiday period. The Simon data systems are sophisticated

[163] Submission No. 48, Dr Stuart Walker, Dr Viginia Watson, Dr Jane Tolman, and Ms Jeanette Palmer, pp. 5-6.

enough now to predict ED attendances +/- <5% error for the next 48 hrs. We know our admission to hospital rate and our discharge from ED rate. We know our staffing roster gaps (noting it is harder to predict sick leave), we know our average length of stay per patient group, estimated discharge date and community hospital capacity. All of this can be amalgamated into a proactive rather than reactive system. This then can be acted on the day prior to the actual event. Elective surgery can be cancelled if necessary, staffing can be bolstered.

o I would also note Simon (used by patient flow) talks poorly to Trak. Beds are allocated on Simon but may not be available for 8-10 hrs) this then comes up as a bed available for an ED patient. This is not a real bed as it is not available for hours.. The Simon dashboard is not used in ED to any great extent but is heavily used by the patient flow team. The disconnected data systems result in failures of communication between ambulance, ED and integrated operations centre staff.[164]

4.9. Dr Scott then outlined how data capture could be improved, and how this could improve efficiency and operation of hospital wards:

To make the data capture adequate:
o The systems need to talk to each other.

o We have become accustomed to extreme ED overcrowding and TCODs as the norm. Just this morning we heard in the hospital wide huddle "ED is looking pretty good." At that time, the ED had 25 admitted patients in 27 acute beds. Essentially leaving us 2 acute bed spaces to manage 220 patients who will arrive throughout the day (30+% needing admission). Despite this, the hospital managers at the huddle were celebrating because it was better than usual (e.g. 27- 34 admitted patients, some of whom have 'slept' in the waiting room or on hard backed chairs in the clinic area). We therefore need to not normalise the extreme disfunction. This is not OK. Each time the ED has more than 8 in patients waiting for that 8 hrs for an inpatient bed this needs to be reported as a dysfunction measure. In addition, it needs to be acted on at a senior level to ensure there is adequate capacity to restore ED capacity and hence prevent TCODs.

o We need to have whole of system data capture and display (both at Department of Health, THS exec level but also visible to all staff). We can then adequately capture the hospital status, we can see what wards are doing things well, we can learn why some wards have improved systems and functions and we can learn from the high performing units and help the lower performers. This may help shed light on the barriers to performance: it may be a lack of infection control cleaners, or a surgeon operating all day so is unable to discharge a well patient home, or it may be cultural factors influencing ward staff behaviour.[165]

4.10. The submission from Primary Health Tasmania noted there was little information available on primary care services. More readily available data would greatly assist in understanding the areas that need improvement:

In the current environment, transfer of care delays are typically communicated through mainstream media and social comment with little information available to primary care services regarding hospital capacity and level of operation. It is difficult

[164] Submission No. 43, Royal Hobart Hospital Emergency Department, pp. 4-5.
[165] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 5.

to help solve a problem when awareness of the problem is retrospective, and data is not available to correctly understand pressure points and measure the impact of interventions or other changes.

The Tasmanian Health System has a dashboard which highlights key measure of performance for the Tasmanian Public Health System — Health system dashboard | HealthStats…

As a practical recommendation, Primary Health Tasmania recommends this dashboard:

- *is updated to provide information in real time in addition to monthly longitudinal statistics*
- *is shared with Primary Health Tasmania as part of a cross organisational agreement outside publication on this dashboard to inform system level planning and reform*
- *is expanded to depict information that includes but not be limited to:*
  - *number of patients with transfer of care delays (Ambulance ramping) and for how long*
  - *level of hospital bed availability*
  - *number of residential aged care patients ready for discharge who are unable to be transferred due to not having a regular GP*
  - *number of patients who presented to ED and were diverted to an Medicare Urgent Care Centre.*[166]

4.11. The Australian Medical Association (AMA) Tasmania also noted the importance of data collection to assist in future planning and offered ideas on data that should be collected:

Efficient and effective data collection is vital for future planning, especially for budget provision, but it is essential for the collection of data not to impede the caregiving or place additional burdens on already overburdened staff. Additional staff and resources will be needed to ensure efficient and effective data collection.

We aren't collecting data on jobs which could be avoided if there was another service to divert the patient to. Especially in rural jobs where an on-call medical service would avoid a drive to DEM [Department of Emergency Medicine]. For example, if the state paid for a GP or a HITH [Hospital in the Home] service to provide services in rural areas this would reduce some jobs needing to go to DEM and sit on the ramp.

Need to collect data on:

- *Avoided paramedic transfers if able to engage with a doctor (e.g., GP)*
- *GPs engaging in HITH or COMMRS*
- *Unnecessary RACF transfers to DEM — e.g., fall with head strike when there is a clear CoG Model Palliative care pathway.*[167]

[166] Submission No. 55, Primary Health Tasmania, p. 7.
[167] Submission No. 50, Australian Medical Association Tasmania, pp. 3-4.

FINDINGS

The Committee finds:

75. There are existing deficiencies with data collection and transparency of data in the Tasmanian Health Service.

76. Current data capture systems in the Tasmanian Health Service are inadequate, burdensome and do not provide an intuitive, interlinked network of communication.

77. Inadequate data collection has resulted in poor statistical accuracy regarding the work and patient flow through the Tasmanian Health Service, including in Emergency Departments, ambulances and ramps.

78. Data collection needs to be accurate, easily available online, and provided in near to real-time to provide a useful measure for day-to-day operations and long-term improvements.

79. Moving patients through the healthcare system would be greatly assisted by having system components that are compatible and able to detect and predict flow blockages before they occur.

Recommendations

The Committee recommends the Tasmanian Health Service:

17. Make data publicly available in relation to:
    a. transfer of care delays, by hospital and level of bed availability;
    b. the number of residential aged care patients ready to be discharged but unable to be transferred to appropriate care; and
    c. the number of patients in the Emergency Department who were diverted to urgent care centres.

18. Expand the data available describing patient care and hospital procedures, facilitate real time updates, and provide access to historical data.

19. Ensure all data systems allow for patients to be recorded as having a status and/or location of 'transfer of care delay'.

20. Publish online, as soon as possible, the information about transfer of care delays contained within Ambulance Tasmania's monthly reports.

21. Ensure the Safety Reporting and Learning System is upgraded to make it accessible for staff to report any incidents or concerns.

22. Work to ensure the data systems between all health areas 'talk' to each other so that a whole-of-system picture is available to staff.

23. Ensure the both the Tasmanian Health Service and Ambulance Tasmania have access to whole-of-system data to better understand where blockages to patient flow are occurring.

5. THE STATE GOVERNMENT'S RESPONSE

5.1. Evidence presented to the Committee regarding the state government's response to transfer of care delays suggested that while some work has been done, it falls short of the whole-of-system change necessary to make a tangible change.

5.2. The Department of Health's (DoH) submission outlined a number of processes and protocols it has implemented to assist with transfer of care delays:

> *Ambulance Tasmania and the THS have also developed several processes and protocols targeted at assisting in management of transfer of care delays and access block. These include, for example:*
>
> *• The Communication Escalation Procedure, which outlines the appropriate notification and escalation of transfer of care delays to support patient safety, assist in managing demand pressures, and to maintain service delivery for Ambulance Tasmania.*
>
> *• The Ambulance Diversion to Waiting Room Procedure, which is a statewide clinical protocol to identify low acuity patients that can be diverted to the ED waiting room under nurse observation instead of remaining on ambulance stretchers. Where appropriate, diversion of patients to the waiting room to await treatment improves the availability of ambulances to provide emergency care to the Tasmanian community.*
>
> *• The Management of Patients affected by Ambulance Transfer of Care Delay in the Launceston General Hospital ED protocol, which sets out communication, clinical care and emergency transfer of care release processes to help in the management of patients affected by transfer of care delays.*
>
> *• The Ambulance Critical Response Protocol, a two-tiered protocol for the Royal Hobart Hospital (RHH) targeted at ensuring "lights and sirens" ambulance emergency responses are not impacted by transfer of care delays. This protocol set outs arrangements for rapid transfer of patients from the ED to other parts of the hospital to release ambulance crews in responses to community demand.*[168]

5.3 Representatives from the DoH noted the current protocols underway to consider adaptive service provisions:

> ***Ms MORGAN-WICKS —*** *We have many protocols. I've mentioned the inter-hospital transfer protocol. We have our communication escalation protocol by duty managers of Ambulance Tasmania on the ramp to make sure there can be consolidation, for example, if there are fours or fives. or those lower-acuity cases, to a single paramedic team to free up ambulance officers to answer calls from the community.*
>
> ***CHAIR*** *— Why are they staying on the ramp at all? Why aren't they going into the waiting room in the emergency department if they're fours or fives?*
>
> ***Mr WEBSTER —*** *That is the protocol you're talking about, the new protocol we announced. Over the next period of time, we will start the process of actually transferring those category fours and fives from the ambulance vehicle and from the ramping area, or transfer-of-care area, to the waiting room as part of the general*

[168] Submission No. 64, Department of Health, pp. 5-6.

triaging, if that's appropriate. It will remain a clinical decision made jointly by the paramedics and the triage nurses. There will be some circumstances where that is not appropriate and it won't happen, but if it is appropriate, they will be transferred to the waiting room.

I'll just comment about the category fours and fives. We talked about this in the Rural Health Inquiry. With a lack of access to general practice, people are not seeking healthcare treatment early enough, and so it is the fours and fives that become the threes, twos and ones causing that increase in acuity in our EDs.

I should also say that this situation would be far worse. The secretary mentioned that the total number going to EDs is reasonably stable but if we didn't introduce secondary triage, which now has around 5000 people diverted each year, if we hadn't introduced PACER in the south, Mental Health Emergency Response in the north-west, there would be far more patients going to an ED.

We have to have a suite that's going from avoiding going into the ED. We're working with the primary-care sector for things like the urgent care centres, the single-employer model to increase the number of GPs, particularly in rural areas, as well as working with practitioners in our hospitals to look at things like criterion-led discharge. We have to, at any one time, have all of these processes happening to actually effect a change in the system around transfer of care. All of those things have the same amount of priority because if we focus on one area, we won't have the result.[169]

5.4 The Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch noted that current government efforts to address transfer of care delays were, in their opinion, inadequate:

The response by State Governments to date has been inadequate in addressing the transfer of care delays and their associated effects. More substantial measures and resource allocation are urgently required to alleviate this crisis.[170]

5.5 Ambulance Tasmania (AT) has implemented a number of measures to assist transfer of care including secondary triage, extended care and community care paramedics and a mandated transfer of care timeframe. The DoH submission outlines the secondary triage measures:

The Ambulance Tasmania Secondary Triage service was established in February 2021 and provides alternate clinical care pathways for people who call Triple Zero and are assessed as not requiring an emergency ambulance response. Secondary Triage has improved the integration and connectivity of Ambulance Tasmania with other health and social service providers, to enable patients where appropriate to be referred to providers that can better meet their specific needs.

Since the Secondary Triage Service commenced in February 2021, as at 31 August 2023, 7 165 Triple Zero calls have been successfully diverted from an emergency ambulance response.

The scope of patients referred to Secondary Triage has expanded since its commencement and will expand further over time, as more alternate clinical care

[169] Transcript of evidence, 5 February 2024, Department of Health, pp. 31-32.
[170] Submission No. 36, Australian Nursing and Midwifery Federation, Tasmanian Branch, p. 5.

pathways are established. For example, Ambulance Tasmania has sent clinical referrals from Secondary Triage to telehealth provider My Emergency Doctor since September 2022. Through the Secondary Triage service, My Emergency Doctor provides specialist medical advice directly to patients in the community, subsequently avoiding an ambulance response. There are approximately 40-50 referrals to My Emergency Doctor each month through Secondary Triage, which has greatly assisted in reducing system-wide demand pressure on emergency services and EDs.

Reducing avoidable ED presentation is a key factor in addressing transfer of care delays. Services such as Secondary Triage are critical in helping to reduce demand on emergency ambulance and ED services.[171]

5.6 The Royal Australian College of General Practitioners (RACGP) noted its support for measures to reduce the impacts of transfer of care delays, such as secondary triage, however noted that such initiatives need to be better underpinned:

The RACGP supports measures that enable the ability of secondary triage paramedics to refer suitable patients to services outside EDs, like the Community Rapid Response Services (ComRRS) or GP led Urgent Care Centres (UCCs). However, this needs to be underpinned by appropriate clinical handover and resourcing to support effective communication between emergency services and primary care.

UCCs that provide supplementary episodic care to patients' when they are unable to access their usual GP, while potentially reducing presentations to EDs, are unlikely to positively impact transfer of care delays. In addition, staffing of UCCs should not impact the broader general practice workforce.[172]

5.7 The DoH also outlined their extended care and community care paramedic initiatives:

Other examples of alternate care pathways which assist patients in the community instead of unnecessarily transporting them to the ED are the Extended Care Paramedics (ECPs) and Community Paramedic initiatives.

ECPs are highly qualified paramedics who provide primary health care in the community. They attend lower acuity patients, assess their needs, provide treatment and refer to alternate medical care providers, with the patient able to remain in their home whenever this is clinically appropriate.

To increase capacity to care for lower acuity patients in the community, Ambulance Tasmania commenced the Community Paramedic service in August 2022. Community paramedics have an increased primary health care focus and are deployed to lower acuity patients in the community to assess and treat patients, aiming to keep them out of hospital where appropriate. There are currently nine community paramedics employed across Tasmania.

Over 2022-23, ECPs and community paramedics diverted a combined total of 1 907 patients from requiring an emergency ambulance response.[173]

5.8 The use of extended care paramedics was discussed in hearings with the Australasian College of Paramedicine (ACP), noting that a further increase in numbers would be greatly beneficial:

[171] Submission No. 64, Department of Health, p. 26.
[172] Submission No. 70, Royal Australian College of General Practitioners, p. 2.
[173] Submission No. 64, Department of Health, p. 26.

Ms DOW *— How many additional community paramedics do you think there should be across Tasmania or the extended care paramedics?*

Ms HAIGH *— Probably significantly more than we have now. We have had one intake and many of those have left areas or have stepped down from the role. We probably need at least two to three per day. If we go 24 hours, then probably three per day in each region, at least. Probably, the larger regions, such as the southern region, probably needs two to three crews on per day of community paramedics to manage the volume of low acuity calls.*[174]

5.9 It was noted by ACP that there was significant value in the use of extended care paramedics however there were blockages to increasing their role, as noted in Chapter 2.[175]

5.10 The opening of urgent care centres was noted by Mr David Pittaway, a registered nurse, as having a positive impact on ED walk-in attendances but do not assist in the area of transfer of care delays:

The opening of the Hobart Urgent Care Centre in Bathurst Street has made a significant difference to the RHH ED Mountain (Mt) care area attendances, and has no doubt been great for the patients treated there faster than otherwise, but it has made no difference to TOC transfer delays in the ED. One could argue that less patients in the Mt area means one or more Mt beds could be used as River area overflow, but the entire Mt area is not well set up for inpatient stays, and the Mt area is not staffed for inpatient stays.[176]

5.11 The Health and Community Services Union (HACSU) noted that several of the State Government initiatives to date have not had a measurable effect as they fail to account for the whole-of-system nature of the problem:

Ambulance ramping delays have placed significant strain on the healthcare system, affecting both patients and health workers. The challenges posed by these delays have necessitated a government response, but their impact is not having any measurable effect on ambulance ramping.

Resource reallocation: *Transfer of care delays have led to the reallocation of resources, including additional funding, staff, and infrastructure, to address the immediate issues arising from these delays. While these efforts are commendable, they have placed a considerable burden on the capacity of the public health system to continue to deal with increasing demand.*

Policy development: *The prevalence of ambulance ramping delays has prompted the State Government to develop policies and guidelines aimed at reducing these delays. These policies have necessitated substantial time and effort in their formulation and implementation.*

The measures in reality are safety processes to attempt to control ramped patients more effectively. This does not seem to have had any positive effect on reducing ambulance ramping, albeit it does provide for a slightly safer environment for our Paramedic members.

[174] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, pp. 5-6.
[175] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 6.
[176] Submission No. 46, Mr David Pittaway, p. 10.

Stakeholder engagement: *The government has engaged with various stakeholders, including healthcare providers, unions, and patient advocacy groups, to address transfer of care delays. These consultations require ongoing resources and coordination.*

Public awareness: *Ambulance ramping delays have gained public attention, leading to increased scrutiny and accountability for government actions. Public awareness has contributed to pressure on the government to respond effectively. However, the issue has been known and worsening for over a decade. The public are rightly concerned that their resources are being used effectively and for the purpose they are designed.*[177]

5.12 HACSU further suggested that an assessment of current measures is needed to ensure that the State Government is appropriately addressing transfer of care delays:

While the State Government has taken several measures to address transfer of care delays, their efficacy and impact on healthcare workers and patients need to be assessed.

Reduction in delays: *The effectiveness of government policies and resource reallocation in reducing transfer of care delays should be evaluated. Have delays decreased, and to what extent, as a result of these measures?*

Worker wellbeing: *An assessment of the impact of government actions on the wellbeing of healthcare workers is crucial. Have measures improved the psychological and physical health of paramedics and other staff affected by transfer of care delays?*

Patient outcomes: *The ultimate goal of government response is to enhance patient care and outcomes. Are patients experiencing improvements in the timeliness and quality of care as a result of government interventions?*

Resource allocation: *An evaluation of the allocation of resources is necessary to ensure that resources are distributed optimally. Are resources being allocated efficiently, and is there a balance between short-term and long-term solutions?*

Data collection and reporting: *The effectiveness of government efforts in enhancing data collection and reporting related to transfer of care delays should be assessed. Is the government now equipped with accurate and timely data to inform decision-making?*[178]

5.13 The Rural Doctors Association Tasmania (RDAT) observed that the Patients First Initiative of 2016 does not appear to have been a success:

The efficacy of the 2016 Patients First Initiative that specified 19 actions to manage demand on Emergency Departments and improve patient flow through the hospital is difficult to assess without access to formal evaluation reports. However, media reports from five years later indicate dissatisfaction with progress. [179] [180]

[177] Submission No. 53, Health and Community Services Union, p. 13.
[178] Submission No. 53, Health and Community Services Union, p. 14.
[179] Submission No. 57, Rural Doctors Association of Tasmania, p. 8.
[180] https://www.abc.net.au/news/2021-01-14/tasmanian-hospital-wait-times-and-ambulance-ramping-continue/13054868. Viewed 10 October 2023. (Footnote 10) and https://independentaustralia.net/politics/politics-display/tasmanias-gutwein-government-patients-first-policy-puts-patients-last,15006. Viewed 10 October 2023 (footnote 11), referenced in Submission No. 57 Rural Doctors Association Tasmania, p. 7.

5.14 RDAT also noted that rural doctors and district hospitals should be more involved in discussions regarding the flow of inpatients to better address pressures on the ramp and in ED's:

> *RDAT is unable to make comments about the Governments implementation of the Review of Ambulance Tasmania Clinical and Operational Service Final Report May 2017[181] report due to the short time frame for submission. We do note, however, that often rural doctors and District Hospitals are 'left out' of the conversation around patient flow, despite multiple acknowledgements that part of the solution is better utilisation of rural acute, subacute and aged care beds.*[182]

5.15 The Royal Australasian College of Physicians (RACP) saw the state government's expansion of virtual health arrangements to be positive, but cautions the need to avoid a one-size-fits-all approach to the modality of consultations:

> *We support the intent and general direction of the Tasmanian Government's commitment to expand virtual health arrangements per the Digital Health — Improving Patient Outcomes Strategy 2022-2032. Virtual health has the capacity to accommodate increased demand, which must be considered against a backdrop of ageing and an increasing incidence of chronic disease in Tasmania.*
>
> *We note one goal of the strategy is to deliver care closer to home "through solutions to strengthen the link between acute and community settings to enable consumers to receive appropriate care in their home for longer and avoid people going to hospital when they do not need to" (Digital Health Strategy, p. 21).*
>
> *The best consultation modality, be it face-to-face, telephone, video or a mix is best negotiated between the clinician and the patient, with specific regard to their unique circumstances, the patient clinical presentation, risk and benefit. This is a position we strongly recommend be factored into planning for Tasmania's Digital Health Strategy so that it avoids the pitfalls of a one-size-fits all approach that fails to account for patient barriers to accessing video, as well as travel, attendance, or affordability constraints to attending in person.*[183]

5.16 In public hearings the Minister for Health spoke of the State Government's increased funding investment in AT:

> ***Mr BARNETT** — … With respect to our investment, we have massively increased our investment in Ambulance Tasmania since we've been in government. We have increased by 220 the number of ambulance officers. In fact, the number of ambulance officers per head of population is 68.4 per 1000 Tasmanians. The national average is 55.7. You've asked me about the past years. When the previous government was in power, it was 43 ambulance officers per 1000 Tasmanians back in 2013. You can see that we've increased this, and we've got record funding for health because we see this as a really serious matter.*[184]

5.17 The Minister further noted the multifaceted approach to funding AT services and paramedics:

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[181] https://doh.health.tas.gov.au/__data/assets/pdf_file/0003/250905/RATCOSFR_v3_LR.pdf. Viewed 12 October 2023, Viewed 10 October 2023, referenced in Submission No. 57, p. 7, footnote 12.
[182] Submission No. 57, Rural Doctors Association of Tasmania, p. 8.
[183] Submission No. 62, Royal Australasian College of Physicians, p. 6.
[184] Transcript of evidence, 8 February 2024, Minister for Health, p. 11.

It's important to note that ambulance responses in Tasmania have increased by 57 percent since we've been in government. This has been matched with a 71 percent increase in ambulance officers. As I've said, we've put on an extra 220. We take this very seriously. That's why we have record funding in our health system, $8.3 million every day. We take it very seriously. Yes, we will be working with the Department of Health, we'll be working with Ambulance Tasmania, we'll be working with our federal colleagues to help make a difference to deliver better health outcomes and to ensure, as a result of the announcement I've made today, you will see more ambulance officers out in the Tasmanian community do what they do best, as a result of that decision today. You'll see that it's a multifaceted response that's required.[185]

5.18 During a hearing attended by DoH representatives, Ms *O'Byrne* put a question on notice requesting data on the numbers of paramedics employed permanently, on a fixed term basis and casually. The information supplied indicated that, as of 9 June 2024, AT had 475 permanent paramedics, 67 fixed term paramedics and 11 casual paramedics.[186]

5.19 When provided in November 2023, the DoH submission noted the intention of the State Government to introduce a mandated transfer of care timeframe:

> *As part of Ambulance Tasmania's enterprise bargaining, a commitment was made to work with the Health & Community Services Union (HACSU) to achieve a mandated transfer of care for all ambulance patients within 60 minutes. The protocol to deliver on this commitment is to be implemented within 12 months of the registration of the new Ambulance Tasmania Award and Agreement, which took place in April 2023.*
>
> *The development of the protocol is taking place through the Transfer of Care Working Group (the working group) which includes representatives from the DoH, including the THS and Ambulance Tasmania, as well as industrial representatives from HACSU, the Australian Medical Association, and the Australian Nursing and Midwifery Federation. The protocol will be different to existing 'urgent offload' practices that are designed to make urgently available an ambulance if there is an outstanding emergency case in the community. This protocol will ensure the business-as-usual practice of offloading all ambulances within 60 minutes regardless of whether there are outstanding emergency cases in the community.*
>
> *This is critical to ensure ambulance availability and deployment of resources across the network of ambulance response areas, which will ultimately reduce emergency response times for life-threatening cases.*[187]

5.20 Just prior to the Minister for Health appearing before the Committee in February 2024, the Government announced a transfer of care protocol. The protocol commenced in April 2024. It mandates the transfer of patient care from AT staff to the care of Tasmanian Health Service (THS) ED staff within 60 minutes of arrival at a given hospital.

At the hearing, Ms *Dow* questioned the Minister as to whether additional resources had been allocated to help support the changes required due to the implementation of the protocol:

[185] Transcript of evidence, 8 February 2024, Minister for Health, pp. 11-12.
[186] Letter from Minister for Health in response to Question on Notice, dated 22 July 2024, p. 2, Appendix C.
[187] Submission No. 64, Department of Health, pp. 26-27.

Ms DOW *— The second question that I have is in relation to your announcement today around the transfer of care protocol, that being the 60-minute time frame. My understanding through the witnesses who have presented to us is that there are concerns around the need for additional resourcing in the emergency departments post that point in time for the staff that will then be providing care to those patients. What additional resources are being provided alongside your announcement today for emergency department staff?*

Mr BARNETT *— It's taken a lot of deliberation and careful assessment by the expert independent reviewers that I announced in September. This is one of their recommendations. However, it is also part of the discussions I've had with the reference group, which includes the unions, HACSU, the ANMF and others. Obviously, the department were very involved in that, with Ambulance Tasmania, and so there's been a lot of hard work of key stakeholders; I thank them all for their work. They support this plan, and this announcement today is my understanding in terms of the outcome, as I say, HACSU have been in contact with me today. I reached out to Robbie Moore, and he's pleased with the outcome. It has a flow on effect across the health system. We're well aware of that and in terms of the -*

Ms DOW *— The question was, 'Will there be any additional resources?'*

Mr BARNETT *— In terms of the resources, I'm sure that the Department of Health and Ambulance Tasmania will work that through the system, and if there's further to say, as part of the budget in coming months, I'm sure we'll be able to share that with you at the appropriate time.*

Ms DOW — [do you] *acknowledge, Minister, that there is a need for additional resources?*

Mr BARNETT *— I think there's an acknowledgement that we want solutions and that we're delivering on the solutions. We've got bed block, we've got problems with disability patients there taking up beds that shouldn't be there, and that's why we're engaging with the Federal Government. We have some 68 beds at the moment blocked as a result of the bed block that's happening across our major public hospitals. That's 42.3 on average for aged care patients and 26.4 on average for our disability patients because they can be discharged today, but there's 68 of those patients that cannot be removed or discharged today.*

Ms DOW *— This protocol doesn't go to that issue at all, and that's my question, was in relation to additional support and resources that will be provided to emergency department staff to provide care to those patients once that care is transferred, and you can't provide me with an answer, so I'll move on.*[188]

5.21 The Committee consequently invited views from several key stakeholders in June 2024 regarding the implementation of the State Government's 60-minute offload protocol, to better consider its effectiveness and impacts.

5.22 The ANMF Tasmanian Branch provided comment to the Committee noting the protocol had failed to improve patient care, resulted in overcapacity, had negatively impacted staff including through insufficient staffing, and increased

[188] Transcript of evidence, 8 February 2024, Minister for Health, pp. 14-15.

the operational pressure on the EDs.[189] In relation to patient care they commented:

> *The procedure has failed to improve patient care. Patients may enter the ED more quickly, but they do not always receive immediate care. At times, the care and monitoring provided in the ED are less adequate than what they would have received on an ambulance stretcher.*
>
> ***…** Many treatment points lack essential monitors, oxygen, and suction. Critically ill patients are sometimes cared for by a nurse responsible for multiple other patients, leading to compromised care.*[190]

5.23 The ANMF Tasmanian Branch also noted the protocol ignores access and flow issues, stating:

> ***Lack of Holistic Approach:** The ANMF's calls for improving access and flow before implementing the procedure were ignored. This has led to deteriorating patient care quality and increased staff stress.*
>
> ***Overcapacity Situations:** Instances like the one at the Launceston General Hospital (LGH) on June 7, where EDs were overrun with patients, ambulances and the LGH ED staff were desperately trying to find monitors from across the hospital to support the patients, while still 7 ambulances were ramped, highlight the ineffectiveness of the procedure without addressing broader systemic issues.*[191]

5.24 The Australasian College for Emergency Medicine (ACEM) also provided the Committee with comment on the new protocol. They noted their previously expressed concerns to the Minister regarding the implementation of the protocol, including that it will do little to address the underlying issues of ramping.[192]

5.25 ACEM expressed concerns about the use of rapid offload policies in general including the potential for them to normalise so-called 'corridor medicine' and a decrease in attention to waiting room patients:

> *Whilst ACEM recognises the different imperatives of ambulance services and ED teams, the College does not support policies that allow for ambulance services to leave a patient in a transition area when there is no capacity within the ED to care for that patient. There have been occasions in other jurisdictions where ambulance services have trialled a 'rapid offload' model-of-care, whereby patients are left at the ED door without any transfer. In that model, ambulance staff cease to continue emergency medical care so that they can respond to other emergencies in the community.*
>
> *Hospitals and EDs are already facing extremely high levels of demand and are staffed by a workforce that have endured unprecedented levels of pressure amidst the backdrop of a global pandemic, an exodus of senior healthcare workers, and chronic vacancy and recruitment issues. They also face the daily moral injury of wanting and being trained to help people, but being placed in a situation of being unable to do this*

[189] Correspondence, Australian Nursing and Midwifery Federation, Tasmanian Branch, p.5, Appendix C.
[190] Correspondence, Australian Nursing and Midwifery Federation, Tasmanian Branch, p.5, Appendix C.
[191] Correspondence, Australian Nursing and Midwifery Federation, Tasmanian Branch, p.5, Appendix C.
[192] Correspondence, Australasian College for Emergency Medicine, p. 2, Appendix C.

to an appropriate level. This means rapid offload is a highly dangerous response, that will lead to greater harm and fewer patients receiving the care they need in a timely fashion.

Emergency physicians are deeply concerned that rapid offload policies becoming business as usual will soon lead to the return of 'corridor medicine' as part of their daily expectations, that patients in the waiting room will effectively be ignored in preference to patients in an ambulance and that non-clinician executives will attempt to direct clinical care.[193]

5.26 ACEM also reported the new transfer of care delay protocol has had little effect on improving the hospital operations broadly, and has resulted in additional conflict between ED staff and AT staff:

Largely, ACEM's members report that the new mandate has had minimal effect on the operations of EDs and the broader hospital. TOC delays are reduced when there is flow throughout the hospital – however, whilst access block and overcrowded inpatient wards persist, there is very little that the mandate can do in these situations.

Our members have reported that the mandate has led to an increase in inter-professional conflict, where you have one party wanting to offload the patient, whilst the other party feel it is unsafe. The TOC mandate has increased the administrative load of ED staff, and ultimately, healthcare workers believe such arbitrary measures simply ignore the key issues that perpetuate the long-standing health system challenges in Tasmania.[194]

5.27 The Australian Medical Association (AMA) Tasmania also provided the Committee with comment on the new 60-minute protocol. They noted that while they support an end to ambulance ramping, they are opposed to the mandatory nature of the transfer of care protocol.[195] They suggested that ramping would not be an issue if the appropriate investment was made into the right services.[196]

5.28 The AMA Tasmania criticised the lack of genuine consultation with other healthcare workers responsible for providing patient care in Emergency Departments, prior to the implementation of the protocol:

… the failure by government to consult properly on the TOCP led the Tasmanian Industrial Commission (TIC) to order further consultation to take place with the AMA and the Australian Nursing and Midwifery Federation (ANMF). While small progress towards a more workable solution was made, it was insufficient to satisfy AMA Tasmania. It remains the position of AMA Tasmania that the consultation process was inadequate as it was limited to the wording of the protocol, and not whether it should be mandated, nor what actions would be required to address the impact of the mandatory transfer of care on ED staff and other parts of the hospital. The fact is, as the mandated TOCP had already been agreed to by government, it was not true consultation and there was no ability to change/ influence the outcome

[193] Correspondence, Australasian College for Emergency Medicine, p. 2, Appendix C.
[194] Correspondence, Australasian College for Emergency Medicine, p. 2, Appendix C.
[195] Correspondence, Australian Medical Association Tasmania, p. 1, Appendix C.
[196] Correspondence, Australian Medical Association Tasmania, p. 1, Appendix C.

of that fundamental aspect of the protocol. The revised TOCP remains a mandatory transfer of care protocol in all but name.[197]

5.29 The AMA Tasmania described the reality of significant access and flow, capacity, discharge, and staffing problems within Tasmanian hospitals. They highlighted the significant negative impact the protocol will have on a hospital system that is already experiencing dysfunctional patient flow:

> *The ability of the ED to comply with expected TOCP standards is entirely reliant on the hospital capacity to function. A measure of how well a hospital is functioning is the reported escalation level each hospital is at. Escalation levels of 3 or 4 means that the hospital is above capacity and measures are required to improve access and flow. These measures regularly include cancelling surgery and other procedures to prioritise flow of Patients from ED into the hospital, and to get emergency patients needing surgery into theatre earlier, at the expense of elective or booked patients. At levels 1 or 2 they have been largely able to comply. Noting in recent weeks we have moved to a Statewide 3-tiered system. The AMA Notes that the level 4 was specifically created at the RHH because of the pressures within the RHH that lead to "internal disasters or code yellows" being called, and this was politically embarrassing to have the RHH declaring a code yellow.*
>
> *To improve this, improvement in efficiencies within hospital systems, as well as additional hospital bed stock is needed. But most importantly for improvements to be sustained they need meaningful resolution to hospital exit block i.e. subacute and nonacute bed stock in the community and boosted community services.*
>
> *Data reporting remains problematic with ambulance reporting seemingly not consistent with data from real time observation and Trak information. To understand the problem, there is a need for investment in clean data capture systems that allow ambulance and hospital systems to transparently talk to each other.*
>
> *EDs are not choked with GP type presentations. A very small percentage (<2%) of ED presentations could be entirely managed by a GP in the community. The message that EDs are being overcrowded with GP type patients is incorrect. The narrative that urgent care centres are making a meaningful impact on ED presentations is optimistic at best. UCC's may stop around five patients a day going to the RHH ED.*
>
> *Ambulance offload to the waiting room processes have had minimal effect on TOCP, as this was already occurring at RHH before the protocol.*
>
> *The reality is Ambulance Tasmania (AT) presentations will not decrease because of the TOCP and access block will continue without meaningful resourcing. RHH senior executives are engaged in seeking access and flow improvements. This is however a very complex task due to under-resourcing, culture and competing service demands. Change will be slow. A protocol of itself is not going to improve access and flow in the hospital and more importantly out of the hospital, which holds the key to the problem.*[198]

[197] Correspondence, Australian Medical Association Tasmania, p. 1, Appendix C.
[198] Correspondence, Australian Medical Association Tasmania, p. 6, Appendix C.

5.30 AMA Tasmania further noted the increased clinical risks at the LGH in particular, resulting from the transfer of care protocol:

> *The Launceston General hospital routinely has patients in ED for longer than 8 hours, and on a daily basis holds admitted patients for greater than 24 hours. With space in short supply, it is not uncommon to have patients on stretchers in corridors, receiving a lower level of nursing and medical care than is optimal because of the lack of space and staff to provide care.*
>
> *Following the implementation of the TOCP [Transfer of Care Protocol], the LGH is accepting patients earlier and filling the front end of ED with ED patients. The airlock has become an ED holding bay rather than an ambulance holding bay. Waiting room medicine is becoming a normal activity and extending significant risk into an unmonitored area.*
>
> *The ED staff have changed their mindset and accept that patients arriving by ambulance or walking in are ED's business. The long stay admitted patients are the problem. But in accepting this responsibility there is an added burden on the ED with increasing numbers of patients waiting in inappropriate clinical areas around the ED and more and more medicine being carried out in the waiting room. This is a compromise in how and where care should be delivered.*
>
> *There is significant clinical risk in the waiting room as ambulance patients are potentially preferentially off loaded while acute patients wait in the waiting room. The nursing allocations have been changed to support an ambulance triage nurse and an offload nurse. These allocations are dependent on staff numbers on the day and with the significant pressure on nursing rosters staff can be spread thinly around the ED. The LGH has also commenced a nurse navigator role which has been created from existing FTE.*
>
> *There have been no additional resources to support the TOCP and access and flow initiatives around the hospital. There is significant work to be done in the hospital system to manage access and flow much of which has been detailed in the recent Piccone ED Review. There is an active conversation each day regarding expected dates of discharge, discharges before midday, use of the transit lounge, utilisation of unoccupied HITH beds, district hospital beds, and privates. Despite this the ED is more access blocked than ever with increasing numbers of patients remaining >24 hours in ED. Recently, as an example, there were 14 patients remaining in ED > 24 hours one week and the ED reached 10 > 24 hours in the following week. This is absolutely unacceptable in most ED's on the mainland. As we know this problem is not an ED problem, rather a result of the dysfunctional flow through the hospital and out into the community (exit block). The LGH is by far the poorest performing hospital in the State due to the long stays in ED.*
>
> *Overall, because of the TOCP there has been some shift in the conversation, but we are yet to see improved access and flow through the system.*[199]

5.31 Similar clinical risks were also noted by the AMA Tasmania at the Northwest Regional and Mersey Hospitals in relation to the introduction of the transfer of care protocol:

[199] Correspondence, Australian Medical Association Tasmania, pp. 6-7, Appendix C.

The TOCP and the ED review have provoked more discussion and focus on access and flow at both sites, however, there have been no new resources allocated to support patient flow initiatives and there has been inconsistent executive pressure on potential levers such as time from previous patient discharge to ED transfer to ward bed. There appears to be a paucity of granular data available to support collective analysis of why patients are not meeting EDD [expected discharge date] or being discharged early in the day, or why a bed is not available. Early discharges are chronically hampered by a significant reduction in JMO [junior medical officer] staffing and no redundancy in inpatient registrar capacity. There are large proportions of inpatients who sail far past their EDD due to lack of NDIS or aged care infrastructure to support them at home or in an appropriate residential bed. Weekend discharges remain up to 20% of those on other days.

TOCP cannot occur unless there is a clinically safe space available for the patient. As no additional clinical spaces have been provided, there has been no change in the ED experience following the TOCP implementation. However, ramping has not been as significant a problem in the NW and the NWRH and MCH generally met the initial target. The higher targets will become more challenging.

While the TOCP has not changed the landscape of itself for any of the hospitals, there is a hope that the Picone ED Review will lead to better resourcing and operationalising of services that will address the challenging problem of ambulance ramping with a whole of system lens.

We need to be mindful the data collected around ramping doesn't reflect reality. It is a signal only. For instance, the mean time difference between actual transfer of care (patient physically off stretcher and handover complete) and AT clinician reporting off-stretcher to comms can be quite different, distorting the data. Having consistent collecting of data between AT and ED would help.[200]

5.32 The Committee wrote to key stakeholders to seek their views on the Picone '*Review of the State Hospitals, Emergency Departments*', released May 2024. The AMA Tasmania noted, in relation to the ongoing lack of inpatient beds and hospital flow, that challenges remain significant despite recent government responses:

The significant challenges facing emergency departments were clearly understood by the review team, however, some of the recommendations to come out of the report are overly ambitious, some only go so far in addressing critical areas such as staffing challenges, and some serious pressure points for our healthcare system have been completely overlooked.

Ask any emergency department doctor about their biggest frustration, and they will tell you it is getting patients admitted into an in-patient bed. Ask any hospital physician, and they will tell you it's not having appropriate sub-acute care beds to move patients into to free up acute beds for the unwell stuck in emergency departments. The human toll of bed blocks is a daily reality they grapple with.

To alleviate the strain on hospital bed capacity, immediate steps must be taken to increase nursing and medical support to residential aged care services, improve NDIS

[200] Correspondence, Australian Medical Association Tasmania, pp. 6-7, Appendix C.

services, and establish integrated primary health care services for individuals with chronic and complex physical and mental health conditions.

The government needs to focus significantly on subacute and frailty care, including bringing forward the building of a new subacute facility at St John's Park. The urgency of freeing up beds cannot be overstated. Many of these sub-acute patients could be stepped down into temporary care facilities while building of a new facility takes place.[201]

5.33 The AMA Tasmania further noted the 2024 Picone review fell short in providing alternative options and solutions to address these critical shortages in beds and services:

Where the review has fallen short is overlooking areas of critical shortage of various types of beds and services in Tasmania. For example, while the report acknowledges the importance of expanding the Hospital in the Home or GEM@home programs, (we need at least 100 more beds), it failed to address the implementation of specialised geriatric care in the hospital, a significant oversight given that Tasmania has the highest population of older people in Australia.

AMA Tasmania has put forth a comprehensive plan for subacute and low acuity care implementation. This includes the use of supplemented bed in Medi-hotel environments with recruitment and retention of appropriate staffing, utilisation of community hospitals' subacute beds, and support for patients in their homes by other community health providers.

The review fails to highlight the critical role of all staff in managing patient flow within our healthcare system while also exposing deficiencies in several key areas. These shortcomings include inadequate capacity to manage tests, results, and patient reviews, as well as insufficient staffing across key hospital departments across the state. We cannot afford to focus on flow management and staff governance without emphasising operational aspects to ensure effective and efficient healthcare delivery.[202]

5.34 Finally, the AMA Tasmanian Branch noted that changes to the delivery of care across the THS and other health providers in Tasmania needs to be collaborative in nature to ensure inclusive and productive solutions:

Expanding the scope of practice of other healthcare providers is not the panacea. AMA Tasmania must be involved in any decisions about changes to clinical care provided by other healthcare providers and not doctors. Doctors are highly trained and cannot be substituted by other healthcare providers without increased patient risk. However, where key integrated areas of delivering healthcare in Tasmania work together for instance, Ambulance Tasmania identifying areas where there might be safer and more efficient ways to deliver care to Tasmanians are welcomed.[203]

5.35 ANMF Tasmania supported the recommendations of the Picone Review, contingent on several factors. They noted the need for an expansion of the community paramedic program, including nurse practitioners; wholistic nursing

[201] Correspondence, Australian Medical Association Tasmania, p. 8, Appendix C.
[202] Correspondence, Australian Medical Association Tasmania, p. 9, Appendix C.
[203] Correspondence, Australian Medical Association Tasmania, p. 9, Appendix C.

care in the community; and an increase in staffing to fix the current substantial staffing deficit across the health system.[204]

5.36 The Committee sought further information from the Minister for Health regarding the effectiveness of the early stages of the transfer of care protocol implementation. In correspondence of July 2024 the Minister noted:

> *There has been a significant reduction in transfer of care delays, reflecting the new protocol as well as significant ongoing effort from hospital staff over the last 12 months to address this challenge.*
>
> *I am advised that data for 2023-24 show there were 9,276 fewer hours of transfer of care delay in 2023-24. This is a reduction of 25.3 percent compared to the prior year, with decreases at all four major public hospitals.*
>
> *This is 9,276 hours of time returned to paramedic crews, ensuring greater availability for emergency responses.*
>
> *Table 1 provides a breakdown by hospital.*[205]

Table 1: Hours of transfer of care delay

	2022-23	2023-24	Change
Royal Hobart Hospital	24,301	19,240	***-5,061***
Launceston General Hospital	10,975	7,134	***-3,841***
North West Regional Hospital	1,048	697	***-351***
Mersey Community Hospital	350	327	***-23***
Statewide	**36,674**	**27,398**	***-9,276***

Note:
1. For the purposes of recording hours of transfer of care delay, the first 15 minutes from arrival at triage within an emergency department is counted as routine transfer of care and any period of time exceeding those 15 minutes as delay. This is consistent with historical reporting allowing for comparability; however, it is recognised that in many instances clinically appropriate transfer of care will take longer than 15 minutes. Accordingly, this measure does not accurately measure transfer of care delays and should be considered alongside other performance information.
2. These data are measured using data from TrakED (the Emergency Department information system). This differs from the measurement of transfer of care within 60 minutes, which is calculated using Ambulance Tasmania informaiton systems.
3. The data for 2023/24 is preliminary, and will be reviewed as part of end of year processes.

5.37 The Minister further noted that the data collected for May and June 2024 has had a positive impact on the data for ambulance ramping across the state's hospitals:

> *The policy has had a positive impact on the percentage of incidents where transfer of care occurs within 60 minutes, with Statewide performance exceeding 80 percent in both May and June 2024, with the preceding months experiencing less than 80 percent.*

[204] Correspondence, Australian Nursing and Midwifery Foundation (Tasmanian Branch), p. 5-6, Appendix C.

[205] Letter dated 26 July 2024 to Committee Chair Dr Rosalie *Woodruff* MP, from the Minister for Health Hon Guy *Barnett* MP.

Table 2 provides an overview of performance against the transfer of care targets.[206]

Table 2: Ambulance Tasmania transfer of care within 60 minutes

Performance Measure	Unit of Measure	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024
Transfer of Care within 60 minutes (Statewide)	Percentage	71%	74%	76%	83%	80%
Transfer of Care within 60 minutes (RHH)	Percentage	66%	63%	66%	75%	74%
Transfer of Care within 60 minutes (LGH)	Percentage	66%	75%	77%	84%	76%
Transfer of Care within 60 minutes (MCH)	Percentage	87%	96%	98%	96%	96%
Transfer of Care within 60 minutes (NWRH)	Percentage	83%	92%	93%	95%	93%

It is acknowledged that significant effort has been undertaken at all the THS facilities to work towards achieving the targets.

5.38 The Committee notes the impact of the transfer of care protocol has varied across hospitals. For example, the Launceston General Hospital (LGH) showed an initial improvement and then a decline in patients transferred within 60 minutes. The Committee also notes this is a short period of data, and as time passes and further data becomes available, we will be able to better infer the true impact of the protocol.

5.39 Further to this, the Minister was asked to comment on how the success of the protocol would be monitored into the future:

> *Within the health service, there has been high visibility of the transfer of care activity, with real-time dashboards operating in Emergency Departments and Ambulance Tasmania operations areas. The dashboards are also accessible to senior members of these organisations, including the Department of Health Executive and other relevant parties.*
>
> *Transfer of care reports are published on a daily, weekly and monthly basis. Where transfer of care does not occur within the 60-minute period, these cases are investigated to determine why this has occurred, to better understand any barriers and implement solutions where possible.*
>
> *In May 2024, the Department of Health launched a new daily Health System Dashboard with a range of new indicators covering emergency department and ambulance performance. This dashboard includes the percentage of patients transferred within one hour, broken down by major public hospital, and can be access online at: https://www.health.tas.gov.au/patients/health-system-dashboard.*[207]

[206] Letter dated 26 July 2024 to Committee Chair Dr Rosalie *Woodruff* MP, from the Minister for Health Hon Guy *Barnett* MP.
[207] Letter dated 26 July 2024 to Committee Chair Dr Rosalie *Woodruff* MP, from the Minister for Health Hon Guy *Barnett* MP.

FINDINGS

The Committee finds:

80. Evidence suggests that while the government has done some work in response to ambulance ramping, it falls short of the whole of system change necessary to address access block, improve patient flow through the hospital, and to improve the delivery of ambulance service in the community.

81. Early evidence indicates the State Government's 60-minute transfer of care protocol, announced in February 2024, has had a positive effect on the time taken to transfer patients from the care of Ambulance Tasmania to Tasmanian Health Service staff and has removed ambulances from the ramp in a more timely manner.

82. The State Government's current transfer of care protocol has not, of itself, improved the length of time patients are spending in Emergency Departments.

83. There are concerns the transfer of patients under the protocol from Ambulance Tasmania staff to Tasmanian Health Service staff is increasing pressure on nursing and clinical staff in the Emergency Department.

84. The transfer of care protocol has not addressed patient flow issues through the Emergency Department, inpatient wards and discharge processes.

85. Without a focus on whole-of-system reforms, the transfer of care protocol only shifts the problem of access block from the ambulance ramp into the Emergency Department, creating additional pressures there.

86. Staffing resources in the Emergency Department have not been increased to manage the influx of extra patients from the ramp needing care in the Emergency Department due to the transfer of care protocol.

87. A failure to adequately increase staffing to accommodate the transfer of care protocol has resulted in additional tensions between Emergency Department and Ambulance Tasmania staff, and additional pressures and stress on Emergency Department staff.

88. The development of new models of care across the health system would benefit from additional investment in:

- Hospital in the Home;
- Urgent Care Clinics;
- extended care paramedics;
- district hospitals and community health centres; and
- increased data collection.

RECOMMENDATIONS

The Committee recommends the State Government:

24. Expand the Hospital at Home program to be available to all Tasmanians.

25. Increase funding for Emergency Department staff to account for the increase in workload resulting from the 60-minute offload policy.

6. MEASURES TAKEN BY OTHER JURISDICTIONS

6.1 The Committee received limited evidence around measures taken by other jurisdictions to mitigate transfer of care delays and its effects. However, some submissions provided examples such as improved data analytics, increased use of telehealth services, extended scope for paramedics and increased funding.

6.2 The Aspen Medical Services submission highlighted that digital health technologies and improved data analytics have improved the effectiveness of health delivery and reduced ambulance ramping in Queensland:

> *The Queensland Audit Office (QAO) published a performance audit report on measuring emergency department patient wait times[208] and has … scheduled a QAO report on minimising potentially preventable hospitalisations. This will also investigate the issues of ambulance ramping at hospitals.[209]*
>
> *The use of improved data analytics is recognised as a key ingredient to productivity improvements. The National Ambulance Data Set integrates existing and developing data sets across the urgent and emergency care system in hospitals and community health, such as the National Ambulance Surveillance System (NASS). It is a world-first public health monitoring system for ambulance attendance data suicidal and self-harm behaviours. [210]*
>
> *Virtual emergency departments staffed by a mixture of GP and emergency medicine fellows have developed across Australia.[211] They provide a digital offering that can help reduce ambulance ramping and encourage the productivity gains required to address ED blockages. In Victoria, the virtual ED pilot showed 87 percent of people referred to the virtual service avoided a trip in an ambulance to the hospital ED.[212] Tasmania could benefit from investing in virtual health offerings, specifically virtual ED and expanding secondary triage and nurse on call services.*
>
> *A range of new digital health technologies can aid triage improvements in EDs. This can also include increased adoption of technology opportunities, such as wearable technologies to improve triage and monitoring in both EDs and ambulances.[213]*
>
> *As an example, since 2016 Copenhagen Emergency Medical Services have trialled the use of artificial intelligence to improve detection of cardiac arrests and strokes. Call handlers have a digital assistant that listens to the conversation and compares that to*

[208] Measuring emergency department patient wait time (Report 2: 2021–22) (qao.qld.gov.au), referenced in Submission No. 47, Aspen Medical Services, p.12, footnote 28.
[209] Acquittal of Queensland Audit Office prior published work plans – June 2023 (qao.qld.gov.au), referenced in Submission No. 47, Aspen Medical Services, p.12, footnote 29.
[210] Ambulance attendances - Australian Institute of Health and Welfare (aihw.gov.au), referenced in Submission No. 47, Aspen Medical Services, p.12, footnote 30.
[211] Step inside the virtual emergency department The Medical Republic, referenced in Submission No. 47, Aspen Medical Services, p. 12, footnote 31.
[212] Virtual Service Expanding to Relieve Hospital Pressures, Premier of Victoria, referenced in Submission No. 12, Aspen Medical Services, p.12, footnote 32.
[213] How Digital Innovations Can Transform Emergency Medical Triage, Centre for Digital Health, Medical School, Brown University, referenced in Submission No. 47, Aspen Medical Services, p.12, footnote 33.

historical emergency calls. The system then sends its predicted clinical severity to the dispatcher.[214] [215]

6.3 The Royal Australasian College of Physicians (RACP) regard telehealth systems, when used appropriately, as a useful tool for increasing accessibility to, and the delivery of healthcare and allowing the Tasmanian health service to provide more care to more patients and reduce hospital presentations:

> *Telehealth systems are a valuable tool for increasing accessibility to healthcare across Tasmania and in other jurisdictions across Australia. However, virtual care may or may not be adequate/appropriate in all circumstances. The current administrative arrangements for public outpatients are complex, hard for patients to navigate, and largely in-hours.*
>
> *Virtual care, including telehealth by phone or video and remote monitoring for symptomatic change, brings the potential for physicians and other health professionals to provide more care to more patients and reduce hospital presentations.*
>
> *Telephone-based specialist consultations are needed, including for complex conditions, are available, particularly for rural, regional and remote patients with geographical barriers to specialty medical access, as well as priority communities with lower incomes, which also have a higher incidence of chronic diseases needing specialist input.*
>
> *In other jurisdictions such as NSW, innovative remote monitoring projects enable real time data to be leveraged in the responsive care of patients with type 2 diabetes and chronic obstructive pulmonary disorder (COPD). These could serve as templates for Tasmania in its development and expansion of the virtual care infrastructure. Virtual care options are essential to the success of Hospital in the Home (HiTH) in Tasmania. As we highlighted in a 2021 submission to the then Independent Hospital Pricing Authority (IHPA), HiTH has been shown to reduce acute and subacute bed utilisation for conditions such as cellulitis, pneumonia and COPD. Appropriate funding mechanisms focused on creating the technological settings required for interoperability between professionals, and between professionals and patients, are needed to realise the benefits of HiTH.*[216]

6.4 New models of care using virtual technologies that can reduce the need for patients to access physical Emergency Departments for care, were discussed by Aspen Medical Services through a case study of the National Health Service (NHS) in the United Kingdom:

> *Lord Carter published Operational Productivity and Performance in NHS Ambulance Trusts in 2018, highlighted that reducing avoidable conveyances to hospital could release capacity in the acute sector. However, the report also acknowledged that alternative services that better meet patients' needs were required. The new models of care are:*

[214] Artificial intelligence in Emergency Medical Services dispatching: assessing the potential impact of an automatic speech recognition software on stroke detection taking the Capital Region of Denmark as case in point | Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine | Full Text (biomedcentral.com), referenced in Submission No. 12, Aspen Medical Services, p.12, footnote 35.
[215] Submission No. 47, Aspen Medical Services, p. 12.
[216] Submission No. 62, Royal Australasian College of Physicians, pp. 6-7.

- *resolving calls over the phone or by virtual consultations (known as 'hear and treat')*
- *treating patients at the scene, including through virtual ED (known as 'see and treat')*
- *taking patients to non-hospital destinations.*[217]

6.5 RACP made a number of recommendations about how telehealth technologies can improve access to care for regional patients:

> *• Ensure telephone-based specialist consultations are available, particularly for rural, regional and remote patients as well as priority communities.*
>
> *• Invest in trialling new models of telehealth and remote service delivery linking secondary and primary care settings, including telehealth hubs in rural, regional and remote areas.*
>
> *• Fund videoconferencing technology packages to building patient capacity and promote equitable access to telehealth, including in rural and regional areas, aged care settings and for patients with a disability.*
>
> *• Develop a funding model and mechanisms for health professionals to enable equitable access to health technologies.*
>
> *• Expand HiTH services, including geriatric evaluation and management in the home, across the state.*[218]

6.6 Rural Doctors Association Tasmania (RDAT) highlighted a number of initiatives that have been employed by other State Governments to mitigate ambulance ramping. They note that these need to be accompanied by clear strategic and operational planning, and thorough review mechanisms. Action from the Federal Government may also be required to address the systemic issue of ambulance ramping occurring across the country:

> *Federal action would appear warranted given the scale of the ambulance ramping problem, and that it is symptomatic of structural issues within the health system. This action must be integrated with state responses to mitigate against duplicative effort and wasted resources.*
>
> *A number of states in Australia have already committed to significant investment in vehicle replacement and the training and recruitment of new paramedics. For example:*
>
> *South Australia committed $36.9 million on new vehicles and $124 million on the recruitment of 350 paramedics over four years.*[219]
>
> *The 2022 New South Wales (NSW) Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales "made 12 recommendations aimed at relieving pressures within the NSW Health system with the intent of preventing delays in transfer of care.*[220] *Of the 12*

[217] Submission No. 47, Aspen Medical Services, pp. 12 - 13.
[218] Submission No. 62, Royal Australasian College of Physicians, pp. 6-7.
[219] https://www.premier.sa.gov.au/media-releases/news-items/biggest-ambulance-fleet-order-on-record-forour-ambos. Viewed 9 October 2023 and https://www.abc.net.au/news/2022-06-05/ambulance-funding-stop-ramping-more-paramedicspremier/101127486. Viewed 9 October 2023, referenced in Submission No. 57, Rural Doctors Association Tasmania, p. 7, footnotes 13 and 14.
[220] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Report%20No.60%20- %20Portfolio%20Committee%20No.%202%20-%20Health%20-%20Ambulance.pdf. Viewed 9 October 2023, referenced in Submission No. 57, Rural Doctors Association Tasmania, p. 7, footnote 15.

recommendations, 10 are supported in full or in principle; one is noted and one is not supported. [221]

The Victorian government has also committed to more support for the health system, including a $162 million package to improve Ambulance Victoria's operations. It has been reported that the Victorian Government initiative is based on the Leeds Teaching Hospitals NHS Foundation Trust, Leeds, United Kingdom model.[222]

Whether these investments lead to a reduction in ambulance ramping remains to be seen. Clear strategic and operational planning that is sufficiently flexible to change what is not working and strong governance that includes robust evaluation mechanisms and transparent lines of accountability must underpin any consequent initiatives.[223]

6.7 Aspen Medical Services supported for the Australasian College of Paramedicine's advocacy for expanding the role of paramedics:

The Australasian College of Paramedicine has highlighted the need to expand the role of paramedics in the new UCCs being rolled out nationwide and including them as part of multidisciplinary teams. This is especially critical as paramedics as a health profession comparatively fewer shortages.[224] *Internationally, ambulance services are transforming their model of care from treat and transport to acute mobile healthcare services, where care is delivered at the scene in an integrated model by accessing alternative pathways.* [225] [226]

6.8 Additionally, Aspen Medical Services noted the need for a reassessment of the role and scope of practice of paramedics, to provide a more wholistic model of care and to reduce hospital admissions. They also note the Federal Government is undertaking a review of this scope of practice:

Redesigning workflows and occupational contours are essential to improving service quality and being open to transformation. The future can't just be about responding when someone wants an ambulance, but instead about playing an active role in supporting local communities to help prevent illness and keep people out of hospitals. A good comparative example is fire services and their work on prevention, including smoke alarm installation.[227]

The Operational Productivity and Performance in NHS Ambulance Trusts report also found that when staff spend more time at the scene with patients, they convey fewer

[221] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2892/Government%20response%20-%20PC%202%20-%20Ambulance%20ramping.pdf. Viewed 9 October 2023 and https://www.nsw.gov.au/media-releases/reducing-pressure-on-public-hospital-eds. Viewed 9 October 2023, referenced in Submission No. 57, Rural Doctors Association Tasmania, p. 7, footnotes 16 and 17.
[222] https://theconversation.com/ambulance-ramping-is-a-signal-the-health-system-is-floundering-solutionsneed-to-extend-beyond-eds-187270 . Viewed 9 October 2023. 19 https://www.nhsconfed.org/articles/what-latest-data-tell-us-about-ambulance-handoverdelays?fbclid=IwAR1uGgNx1m--nlGgKtvI9qQu4Q6Y7lNVaafs3Dh0WyOoJb7eCEGIbYAbKeo. Viewed 9 October 2023, referenced in Submission No. 57, Rural Doctors Association Tasmania, p. 7, footnotes 18 and 19.
[223] Submission No. 57. Rural Doctors Association of Tasmania, pp. 7-8.
[224] The Australasian College of Paramedicine (paramedics.org), referenced in Submission No. 47, Aspen Medical Services, p.13, footnote 36.
[225] The Alternative Pre-hospital Pathway team: reducing conveyances to the emergency department through patient centred Community Emergency Medicine, BMC Emergency Medicine, Full Text (biomedcentral.com), referenced in Submission No. 47, Aspen Medical Services, p.13, footnote 37.
[226] Submission No. 47, Aspen Medical Services, pp. 12-13.
[227] Ambulance services and integrated care systems: lessons for effective collaboration, NHS Confederation, referenced in Submission No. 47, Aspen Medical Services, p.14, footnote 42.

patients to hospital and are therefore able to see and treat more people.[228] *This highlighted the need to increase the clinical capacity of paramedics and to shift to new combinations of clinical staff to enhance ambulance clinical service models. The Australian Government is undertaking a Scope of Practice Review — Unleashing the Potential of our Health Workforce, which is primarily focused on exploring opportunities and innovations in primary care.*[229]

The development of the extended care paramedic (ECP) has expanded the scope of practice of paramedics to provide:

- *patient assessment*
- *recognition and management of minor illness and minor injury presentations*
- *provision of definitive care*
- *referral to community-based health services for a range of presentations.*

ECPs have successfully reduced the number of patients being unnecessarily transported to EDs by 60 percent compared to usual care.[230] *The College of Paramedicine suggests a new era of a primary health paramedicine is one that doesn't focus on paramedics in an ambulance. Instead, it focuses on chronic conditions, long-term health goals and looking after the whole wellbeing of a patient.*

This does require systemic changes, including the Australian Government creating and funding an MBS item number for paramedics.[231] [232]

6.9 Mr John Bruning, a representative of Australasian College of Paramedicine (ACP), suggested that models of care should be amended to provide for multi-disciplinary support teams - including paramedics, nurses and doctors - to provide care outside of the hospital setting. This in turn can assist in circumventing demand on ED's:

***Mr BRUNING** — … We know that even when we have nurses in aged care facilities, we are still having ambulances and paramedics attend and transfer patients and because it is felt that it's not safe to leave them in the facility and they end up having to be taken to the emergency department. This is a case where that person probably does not need the facilities at the hospital, but they need ongoing care which has gone above and beyond what is currently available to them.*

Our recommendation is not just paramedics but team-based care, a multi-disciplinary team of paramedics, nurses, GPs, doctors who are able to work together and provide care, either in the home or in the aged care facility and means that they do not go to hospital except when they need the facilities that the hospital provides. That is what we are transferring this group who do not actually need that care. What we have seen across jurisdictions is one of the big issues with bed block in the hospitals, with the emergency department, is the safe discharge of patients who have ongoing health needs.

[228] on-the-day-briefing-carter-ambulance-report.pdf (nhsproviders.org), referenced in Submission No. 12, Aspen Medical Services, p.14, footnote 43.
[229] Scope of Practice Review - Terms of Reference (health.gov.au), referenced in Submission No. 12, Aspen Medical Services, p.14, footnote 44.
[230] Ambulance NSW (Digital Health) - SNPHN Partnership (sydneynorthhealthnetwork.org.au), referenced in Submission No. 12, Aspen Medical Services, p.14, footnote 45.
[231] The Australasian College of Paramedicine (paramedics.org), referenced in Submission No. 12, Aspen Medical Services, p.14, footnote 46.
[232] Submission No. 47, Aspen Medical Services, pp. 13-14

We have been talking federally to the Government about the role paramedics can play in supporting discharge of patients and the care of patients in aged care facilities. We run into that hole between state and federal as to who really wants to make this work as effectively as possible because it benefits both sides, but it might be seen that it helps the hospital more therefore it is not as big a concern. It is definitely what is going on with the care our community needs that this is a big factor.

Can we stop people going in and can we help them come back out? If we can get that right, we would address a lot of our challenges.[233]

6.10 The Chair further questioned Mr Bruning as to whether or not this multi-disciplinary approach had been undertaken in other jurisdictions:

CHAIR *— Are you aware of any evidence coming from those facilities or is it too early for data to have been collected to talk about avoided hospitalisations?*

Mr BRUNING *— I haven't seen any data at this point in time and it's only anecdotal. There was recently a presentation at a health workforce summit by the CEO of Mercy Care saying how impactful the paramedics had been in providing better care to their community, but nothing that is yet shown in the data in terms of addressing presentations to ED. This is what we need. We are in this chicken and egg situation where we're fairly sure it's going to make a big difference if you do it, but we need someone to go and do it and research to show.*

There's a lot of examples internationally, especially with Canada, where this work is showing real positives. They now have paramedics at clinics. They have paramedics doing community care. There was a small group in Canada that were high frequency ambulance users and being transported to ED, so they made a community paramedic and a community nurse available to this group of 15 people. I think their figures were saving $ 1 million in a year by just taking care of this group of people in the community, rather than transferring them to hospital all the time.[234]

FINDINGS

The Committee finds:

89. Telehealth and virtual health services can reduce the impact on hospital facilities by providing access for care outside of physical General Practitioners, ambulance and hospital settings.

90. There are insufficient telehealth and virtual health services in Tasmania.

91. The availability of telehealth and virtual health services particularly impacts on regional Tasmania, where there is difficulty accessing physical health services.

92. Multi-disciplinary out of hospital care teams and Hospital in the Home services alleviate pressure on hospitals by providing more holistic care, and thereby decreasing hospital presentations.

[233] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 7.
[234] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 8.

93. Extending the role and scope of practice of paramedics would provide them with an increased range of multi-disciplinary emergency skills. This would allow them to care for people in both homes and facilities, reducing avoidable hospital admissions and use of ambulance services.

94. Increasing the number of extended care paramedics in the community would decrease admissions to the Emergency Department via ambulance through providing care directly in the community setting.

RECOMMENDATIONS

The Committee recommends the State Government:

26. Commit to a full whole-of-system assessment of the Tasmanian Health Service to provide a thorough scope for change across all levels of the system.

27. Appoint a person with oversight of patient flow with the responsibility for identifying and reporting on system-wide initiatives to address patient flow.

28. Invest in, and expand, the extended care paramedic and community care paramedics programs, with a focus on assisting patients in aged care facilities.

29. Undertake an assessment of human resource employment matters including, but not limited to, contract type, retention, recruitment, pay scales, rostering, breaks and entitlements.

30. Continue to work with the Federal Government to improve primary and community care alternatives to improve hospital flow, including access to General Practitioners' services and the discharge of aged care and National Disability Insurance Scheme patients.

7. FURTHER ACTIONS THAT CAN BE TAKEN

7.1. The Committee's final term of reference requested information regarding short, medium and long-term actions that can be undertaken by the State Government to address the causes and effects of transfer of care delays. The Committee received substantial evidence regarding this matter.

7.2. Before further detailing the direct evidence received during the Inquiry process, the Committee wishes to again draw attention to existing reports undertaken in the area of transfer of care delays in Tasmania, notably the Newnham-Hillis Report of 2019 and the report of the Auditor-General, also released in 2019. The Committee received evidence from multiple submissions and witnesses regarding these reports and their ongoing relevance to the current causes and effects of transfer of care delays in Tasmania.

7.3. Professor Harvey Newnham and Associate Professor David Hillis released '*Towards outstanding care at the Royal Hobart Hospital: External consultation for ED advisory panel – a review of patient access at Royal Hobart Hospital*' (Newnham-Hillis Review) in August 2019.[235] The Department of Health (DoH) requested this review in early 2019.

7.4. The Newnham-Hillis Review provides recommendations across numerous areas of hospital care and processes including system and organisational enablers, patient–flow, admission and discharge procedures, and diagnostic specific considerations. The Committee notes that evidence received in the current Inquiry denotes the continuation of the causes and effects of transfer of care delays as considered by Newnham-Hillis. The Committee acknowledges receipt of the report from submitters to the Inquiry.[236]

7.5. The Committee also notes the report of the Tasmanian Auditor-General titled '*Performance of Tasmania's four major hospitals in the delivery of emergency department services*' (Auditor-Generals Report), published in May 2019.[237] The Auditor-General's report assesses the operations and performance of the four major Tasmanian hospitals from the period of 1 July 2009 – 30 June 2018.

7.6. The Auditor-General's report concluded that Tasmania has an ineffective hospital system. It recommended urgent action to assess patient flow, and the culture and leadership of the Department of Health (DoH) and Tasmanian Health Services (THS). The Committee encourages the consideration of the Auditor-General's recommendations, noting it has been five years since the report was handed down.

7.7. The Committee finally notes the publication of the '*Independent Review of Tasmania's Major Hospital Emergency Departments*' by Debora Picone AO (the

[235] 'Towards Outstanding Care at the Royal Hobart Hospital: External Consultation for ED Advisory Panel (EDAP) - A Review of Patient Access at Royal Hobart Hospital', 5 August 2019, Professor Harvey Newnham and Associate Professor David Hillis, https://doh.health.tas.gov.au/__data/assets/pdf_file/0004/416821/Newnham_and_Hillis_Review_-_2019.pdf

[236] Submission No. 48, Dr Stuart Walker, Dr Virginia Watson, Dr Jane Tolman and Ms Jeanette Palmer.

[237] 'Performance of Tasmania's four major hospitals in the delivery of Emergency Department services,' May 2019, Auditor – General, https://www.audit.tas.gov.au/publication/performance-tasmanias-four-major-hospitals-delivery-emergency-department-services/

Picone Review) in May 2024.[238] The Picone Review assessed the current challenges of patient access and flow experienced in hospital EDs, ambulance services, inpatients wards and other health services. It provided recommendations that are patient and staff focused, as well as recommendations to address systemic and cultural changes.

7.8. The Committee notes Dr Formby's specific suggestions for actions that can be taken in relation to residential aged care facilities and improving ambulance triaging of patients:

> *3. RACFs [residential aged care facilities] are a Commonwealth responsibility but this doesn't mean that the Tasmanian government is powerless to act. It should co-operate with RACFs to improve care and gain the support from the Commonwealth to achieve this. If RACFs are performing poorly, are stone-walling reform and there is data to back this up, the state government should name and shame them. The state should improve access to HiTH [Hospital in the Home] for aged care … outreach services need to be supported by appropriately-skilled doctors, visiting the patient in the RACF, if the patient's GP is not available. It would be cost-effective even if the doctor was paid by the Tasmanian government. Patient care assistants, who could assist with returning the patient to bed, should be part of the HiTH team. Similarly, it would be cost-neutral if sitters for confused patients were sent to the RACF from the hospital pool, as they would be required anyway if the patient was transferred to hospital. The Tasmanian government should attempt to recover some of these costs from the RACF, which would improve the health budget.*
>
> *4. Develop Health Pathways (Kings Fund Report) for the management of common conditions. The plans should enable the ambulance triage of categories of patients to an Urgent Care Facility (UCF) rather than a hospital emergency department. The UCF would provide comprehensive treatment so that the patients could then return home. Only if the triage proved to be inaccurate would they need to go to hospital. All staff in the UCF should be trained to a high standard so they could confidently manage the range of conditions they would be expected to see.*[239]

7.9. Representatives from the Australasian College of Paramedicine (ACP) discussed the potential reasons for the current limited success in implementing community paramedics in the Tasmanian health care setting and how this can be addressed:

> ***Mr BRUNING*** *— Yes. That's one of the things they do. They do that as well. One of the challenges as to why it hasn't been done yet in rural and remote Tasmania is there might be a feeling they are going to not have stuff to do for periods of the day, so they are ready to go when someone needs them, but what are they doing the rest of the time. In Canada they have worked that out by putting them in small hospitals, clinics or urgent care centres and do both functions. They are in a clinic doing work, now you need to go to the aged care facility, someone there is a bit more unwell, then they go do checks and do daily rounds to different facilities.*
>
> *You need to build a mix of care, especially in rural and remote areas of how that community paramedic is working to get the greatest benefit. You want them available, and I think we got to the point where we expect everyone to be 100 percent*

[238] ' Independent Review of Tasmania's Major Hospital Emergency Departments', 7 May 2024, Chair – Adjunct Professor Debora Picone AO, https://www.health.tas.gov.au/sites/default/files/2024-05/independent_review_of_tasmanias_major_hospital_eds.pdf

[239] Submission No. 74, Dr Frank Formby, pp. 3-4.

utilised and when everything is 100 percent utilised as soon as you have a surge you have got a problem that people have to wait. You need people utilised not to 100 percent, but if you can use them in other ways and then pull them from that to go to the care you need delivered you get the best of both worlds.[240]

7.10. Mr Hamish Wallace, an intensive care paramedic, noted previous effective actions that have been implemented by Ambulance Tasmania (AT) to help keep patients out of hospital. He encouraged the need for more investment in particular areas:

During my time I have seen the Ambulance service create avenues to keep patients out of Hospital. Examples include, Secondary triage, Community Paramedics, Extended Care Paramedics, PACER programmes and the introduction of Pre-hospital thrombolysis. I believe more needs to be invested into these areas. Perhaps the Ambulance service can form greater connections and partnerships with other Ambulance service and use their clinical interventions, programmes and research.[241]

7.11. The Committee also heard evidence regarding the expansion of extended care paramedic programs, alongside community care paramedics, and actions that can be initiated in the short-term and implemented into the future. Mr John Bruning, from ACP, discussed this matter:

Mr BRUNING *— … Currently, we have a nine percent year-on-year growth in registered paramedics. We have had a mass hiring but it's likely that before COVID-19 half of our graduates couldn't get jobs. We had 1000 registered Australian paramedics on the UK register working in the UK, so we have great interest in being a paramedic and there are opportunities for paramedics working collaboratively with nurse practitioners, with nurses and with GPs to provide the care we need.*

There will be some overlap, but there's some overlap across most of the health professions in terms of what they can do. If you have a nurse, nurse practitioner, a paramedic and a GP, you actually have a full range of care from acute, which the paramedic brings more of, to the chronic, which maybe the nurse practitioner brings more of, to the GP, who is like the team captain of this care. We can get fantastic care for our community by looking at that team model.[242]

7.12. Witnesses from the Australian Nursing and Midwifery Federation (ANMF) Tasmanian Branch also provided evidence about the importance of expanding the Community Rapid Response Service, community dementia teams, and twenty-four hours, seven day a week, palliative care services to help reduce pressure on hospitals:

Ms SHEPHERD *— … there are patients who present to the emergency department who could be receiving care at home or in the community, or, obviously, for those from residential aged-care facilities, in-facility.*

The Community Rapid Response team has been absolutely instrumental in supporting the prevention of emergency department presentations in the community. They can be referred through to that service from direct referral from general practitioners and from those facilities as well. I think that provision of care that is nurse practitioner-led as well can provide that acute supportive approach to those patients who might need

[240] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 8.
[241] Submission No. 72, Mr Hamish Wallace, p. 1.
[242] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 11.

that increased care but not necessarily as an emergency in an emergency department. Those types of services and teams have been absolutely critical in preventing admissions.

Looking at other services, palliative care, for instance, we know is only funded, again, to business hours. Often we hear from members in the emergency department that they have presentations of palliative care patients, particularly in the terminal phase where there might be pain issues, or there are other types of concerns that have come up that they can't deal with over the phone, and they have no other alternative but to present to the emergency department. Having a 24/7 palliative care funded service would obviously assist in that regard.

Thinking more broadly as well in terms of community services, we've got our community nurses functioning in the community. We know from Community Rapid Response, having that referral and the oversight by nurse practitioners could be an added benefit to the community nursing teams; to have those nurse practitioners within the community nursing teams for that escalation to try to prevent those patients who might then bounce back post-discharge, or even in community receiving ongoing community care.

Other services like the community dementia teams, who are instrumental in supporting those patients living with dementia, where they can go in to provide that additional top-up to federally funded packages. But being able to be more flexible, so that they can just go in for 10 or 15 minutes and assist with medication administration so that there's not the issues around polypharmacy or critical medications being missed. Then you're not having syncope or people having falls or fractured hips as a result.

I think exploration of those existing services and how they can be expanded is probably also quite a cost-effective measure in terms of trying to look at supporting the reduction in inappropriate emergency department admission.[243]

7.13. The ACP also provided evidence and recommendations to the Committee regarding the restructure of care through the provision of twenty-four-hour secondary triage services, and an expansion of patient transport systems:

Ms HAIGH *—… secondary triage is not a 24-hour service; neither are the community paramedics. I believe there is an opportunity there to really provide better care and better outcomes, if we can have those clinicians 24 hours. Secondary triage does a lot of diversions away from ambulance, and they also do a lot of diversions to the community paramedics. On top of that, we believe it also needs an expansion of patient transport, because at the moment, they work during the day and then do on call of an evening when, really, they could be assisting with moving some of these patients around and getting them out of hospital.*

… It needs a good investigation into what is going to be best for the needs of Tasmania because if we rely on other services, it is not necessarily what we need here. As you are aware, there is limited access to GPs, there is limited access to a lot of primary and preventative health. Palliative care is difficult to get into because they are just so overwhelmed with patients. I think this is a big opportunity for ambulance

[243] Transcript of evidence, 14 December 2024, Australian Nursing and Midwifery Federation, Tasmanian Branch, pp. 8 – 9.

to be able to make a difference here with these patients. Urgent care centres have helped with the diversion to urgent care centres as well.[244]

7.14. Additionally, the Committee received recommendations from Primary Health Tasmania to better use Medicare Urgent Care Centres as a means of additional diagnostic care:

Ensuring Medicare Urgent Care Centres are well supported and scaled to meet the intended capacity goals of the initiative, particularly around access to after hours x-ray services which is an emerging service gap due to concerns of private x-ray providers on the commercial viability of operating in after- hours periods.[245]

7.15. Dr Paul Scott, Acting Director of the RHH Emergency Department, detailed the benefits that could be achieved by assessing and improving patients tracking policies:

Dr SCOTT *—… A problem we have in the health system is the patient tracking systems that Ambulance use don't talk cleanly to the emergency department systems and they don't talk cleanly to the inpatient systems that allow patient transfer through the hospital system. The reason for that is, I guess, that a non-integrated approach was taken to look at the data system managements that the various aspects of the pre-hospital and hospital environments use and that has meant that they don't integrate very well.*

However, there is enough sophistication in those systems to predict the type of load that we will experience in the ED on a daily basis and that the hospital will experience in terms of the number of patients requiring admission. We can also predict other factors like the length of stay that a general patient cohort may need. We're looking at short to medium-term fixes, having information systems that can predict the number of patients that will actually present the next day as well as real-time feeds in terms of activity. If I know there are seven ambulances half an hour away from the emergency department, I need to know that they're coming in and I need to create immediate space and be able to escalate and clear space out of ED, ideally to move patients up to the ward to be able to accommodate those ambulances.

At the moment, we don't do that. Not only is there predictive data that we can look 48 hours ahead with very good accuracy to work out how many patients are going to attend the emergency department, but also the very short-term predictive power which is, 'hey, I'm about to get five ambulances in the next 20 minutes', we don't clearly capture. That makes it very difficult when we suddenly have to find four or five lay-down spaces, perhaps in a car accident in Tea Tree within a short period of time. Hopefully that answers your question.[246]

7.16. The Committee heard a considerable amount of evidence about the need to increase staff support, especially for Ambulance Tasmania (AT) staff, to address the ongoing impact ramping is having on their mental health and wellbeing. Representatives from the Health and Community Services Union (HACSU) were questioned regarding the lived experience stories they had gathered from Ambulance Tasmania staff:

[244] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 5.
[245] Submission No. 55, Primary Health Tasmania, p.11.
[246] Transcript of evidence, 23 January 2024, Dr Paul Scott, pp. 7-8.

CHAIR *– I want to start by talking about the recent staff survey that you have undertaken. I understand that 67 percent of HACSU ambulance members said that they'd consider leaving Ambulance Tasmania because of ramping. Do you think that sentiment is reflected in the real changes that we're seeing in the workforce? Are people leaving? Are they reducing their work hours?*

Mr DIGNEY *— Yes, they are, Chair. Increasingly our members are seeking part-time work arrangements or considering work outside that of an operational paramedic because of the pressures caused by ambulance ramping. We see week after week members of our ours who are employed as full-time equivalent paramedics seeking a reduction in their work hours and that is mainly due to the workload that's caused by ambulance ramping.*[247]

7.17. The additional evidence about the severity of mental health impacts provided by HACSU members, points to the critical need for more workplace support:

CHAIR *— What are you hearing from members about the changing conditions on the ramp and how it's affecting people's mental health? I've read some of the comments in the report.*

Ms HAIGH *— It's quite devasting, really. You have to take into consideration the whole approach to this because already the job is potentially damaging for mental health. Then, on top of that, to be stuck in a hospital with a patient. Particularly in the last couple of years, as you've pointed out, it's increasingly worse and higher acuity patients being ramped. It's not unusual for what is classified as a Category 2 patient, who is quite unwell, to be ramped. That adds extra stress to paramedics all the time. It's not a one-off event that this is happening; this is happening nearly every day that they are stuck with these sick patients.*

Not only are they in these stressful situations with these sick patients, where at times, as we know, some people have died on ramps because their illness has progressed suddenly, but also, we need to remember the people out there in the public, so there's a moral injury that also goes with this.

All paramedics are expected to carry a portable radio on them. They can hear what is going on out in the rest of the community and they can hear: P1, which is an emergency case, Glenorchy, no response; P1 Launceston, no response. That is an emergency case. What a lot of people forget is that the patients who are on the ramp are actually in a hospital but the patients who are out there in the community have no one there to look after them when they are suffering their medical emergency. It's really difficult for paramedics to not only be stuck on the ramp with patients that they can't get the best care for because paramedics are obviously limited with what they can do. They are also hearing all these other cases going off where there is no response and no support for these patients.

The reason why we [ambulance Tasmania staff] are here is to look after the people of the community and we are unable to do that. That causes great distress and moral injury to them.[248]

[247] Transcript of evidence, 14 December 2024, Health and Community Services Union, p. 17.
[248] Transcript of evidence, 14 December 2024, Health and Community Services Union, pp. 17 – 18.

7.18. The CEO of Ambulance Tasmania Mr Jordan Emery, noted the current processes being undertaken to implement psychological support structures in the short-term, and plans to advance these supports into the future:

> ***CHAIR*** *— When do you expect to finalise a decision about mandatory psychological support for Ambulance Tasmania staff?*
>
> ***Mr EMERY —*** *I would think that we would make a decision within the first six months of this year. The sticking point is about mandatory assessments.*
>
> *We continue to provide a broad range of psychological supports to the workforce now. They are very comprehensive services. Some of our support also includes outside of the wellbeing framework where people might see a private psychologist and get assistance, which we will pay for.*
>
> *Speaking candidly, I think we need to do some more work around whether we would impose upon employees a requirement to undertake a psychological assessment and appropriately work through what we can do to support people who might have a finding that is inconsistent with their own wishes or aspirations professionally.*[249]

7.19. Mr Emery also detailed the work being undertaken to address the impact of current workloads on paramedics, including through procedures for end of shift protections and a roster review working group:

> ***Mr EMERY*** *— … We are working very closely with the Health and Community Services Union, through our roster review working group, to try and develop more contemporary rosters that better support the different type of working arrangements our workforce is seeking. HACSU has a number of representatives on that working group and their input is very important. We are very close to finalising end-of-shift protections procedure that imposes restrictions on how we task paramedics in the final hour of their shift so that we can get them home to their families more often.*
>
> *We are working on mandated transfer-of-care provisions, so that we can reduce the impact of transfer-of-care delays on paramedics. As I touched on earlier, Ambulance Tasmania, with support from the Department of Health, has a submission into budget for additional resourcing so that we can continue to meet the increasing demand on ambulance services that we are experiencing.*[250]

7.20. The Committee also heard evidence regarding the necessity of adapting employment practices, including through providing permanent contracts rather than fixed-term contracts, to support and retain staff:

> ***Ms Haigh*** *- Probably one of the biggest difficulties at the moment … is fixed term contracts and no permanent employment. People are leaving because they want permanent employment rather than the insecurity of fixed term contracts.*[251]

7.21. Additionally, the submission provided by staff from the Royal Hobart Hospital Emergency Department noted employment practices and procedures, alongside recruitment and rostering considerations, as medium-term actions for change.

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[249] Transcript of evidence, 5 February 2024, Department of Health, p. 12.
[250] Transcript of evidence, 5 February 2024, Ambulance Tasmania, pp. 14 – 15.
[251] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p. 6.

They specifically note the need to shift to a seven day a week model of hospital discharge:

> *A cultural change to 7 day per week work week to allow hospital discharges on the weekend and investment in understanding the causes and impacts relating to access block are important. We currently have a scatter gun approach to 'fix' access block without looking at the entire picture. Increased investment in Statewide workforce planning and proactive and efficient recruitment services is desperately needed. A healthier ED and hospital workforce will allow us to fully utilise hospital beds and ease access block, improving TOCDs...*[252]

7.22. The ANMF Tasmanian Branch proposed a number of initiatives to improve patient flow throughout the hospital. These include 24/7 radiology, pathology and pharmacy; additional pharmacy technicians to support discharge; Nurse Navigator positions in each hospital ED; and an expansion in the role of Nurse Navigators to give them responsibility for discharge planning with patients and families at the time of admission:

> ***CHAIR*** *— You have talked in your submission: The primary cause is the bottleneck within hospitals due to limited capacity and inefficient flow of patients. Can you talk about the role of what nurses would like to see to have more efficiencies in the flow of patients? …*
>
> ***Ms SHEPHERD —*** *… In terms of the 24/7 radiology pathology, also pharmacy as well. Patients might be fine for discharge but then they are waiting for hours to get their discharge medication and that patient presumably could have been — yes, some might go to transit lounge but then presumably that patient was fine for discharge but then waiting for hours. So, additional pharmacy technicians to be able to support the provision of timely discharge medications.*
>
> *….*
>
> *… there aren't any nurse navigators at the LGH or North West Regional or Mersey — they're the types of people who are really focused on access and flow and moving patients in and discharging patients out; identifying those patients who might have complex needs on discharge, sending early referrals, ensuring there are multi-disciplinary meetings occurring to ensure that care pathway can actually be streamlined.*
>
> *Some of those roles are still carrying a patient load while also trying to coordinate the flow of patients into and out of wards. Working with the bed managers and that is a really critical role, we feel, in terms of access and flow. We also think that there could be a broader role in terms of nurse navigators not just in the emergency department but to try and facilitate the appropriate transfer of care of patients, working with patients and families around discharge destination at time of admission or presentation to the emergency department…. …. I think part of the issue is that the medical team, or surgical team or whatever specialty it might be, will be responsible for diagnosis and estimating the date of discharge. The nursing staff then obviously are providing care to the patient in the admittable ward or unit but also too then responsible for discharge planning. Often those conversations around discharge planning don't occur until the patient is on the ward or unit. If we can facilitate*

[252] Submission No. 43, Royal Hobart Hospital Emergency Department, p. 6-7.

somebody with a broader lens to look at discharge planning from admission to actually oversight that process…'[253]

7.23. Ms Shepherd further recommended a complete workflow and structural reassessment of the THS:

> ***Ms Shepherd*** *- …In the context of access and flow, in an ideal world people would come into the waiting room in the emergency department, they'd be triaged, allocated a bed and within four hours you would either be discharged home or you would be admitted to an in-patient bed and moved out of the emergency department. We know that this isn't happening. We've got some of the worst wait times in the country, particularly at the LGH. As James said, the issue around that is multifactorial in terms of the causes, predominantly because we know that patients aren't all one capacity, and I don't mean this in a derogatory way, but of course the demand is increasing. We do have an older population with multiple chronic diseases, so demand and the complexity of patient presentations is also increasing over time as well.*
>
> *We also know that there is a cohort of patients who are admitted through the emergency department who have longer stays than others, which those might be who require aged care placement to post discharge, may not have had any ACAP processes undertaken prior to admission. It might be they present with a fall and then a decision is made for us to transfer to residential care. Increasingly, the numbers of those patients who are receiving NDIS support who might need alternate living arrangements on discharge are also causing significant delays in terms of discharge. What that means is when we have cohorts of patients who aren't moving out, as James said, in a timely way to discharge. At the other end we've got increasing presentations and a bottleneck effectively of people not being able to move out of the emergency department. It's just a perpetual cycle.*
>
> *Some of the other system issues that contribute to access and flow from an ANMF perspective are that a lot of the services and supportive services to healthcare delivery are staffed to business hours. So, we know in terms of radiology, pathology, they're business hours. If we want to be able to move people out of the emergency department, we really need to be able to ensure those patients can get their investigations and pathology, radiology, et cetera, in a timely way so they can have a definitive diagnosis and either be admitted or discharged.*[254]

7.24. Representatives from the Australasian College of Emergency Medicine (ACEM) were asked by the Committee to suggest their responses to the issue of serious access block. They spoke to the need for whole of hospital solutions, rather than bandaid fixes:

> ***CHAIR*** *— …We've heard from the Launceston General Hospital that [access block] 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*** *— …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*

[253] Transcript of evidence, 14 December 2023, Australian Nursing and Midwifery Federation, Tasmanian Branch, pp. 6-7.
[254] Transcript of evidence, 14 December 2024, Australian Nursing and Midwifery Federation, Tasmanian Branch, pp. 3 – 4.

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.[255]

7.25. Dr Ben Dodds, representing the Rural Doctors Association Tasmania (RDAT), suggested the need for a strategic review of the district hospital network and community health centres including infrastructure and clinical service provision:

> ***Dr DODDS*** *— We need to examine what those district hospitals and community health centres are currently doing, because I think no one really knows. They have historically branched out in their own way over a number of years through neglect and designed their own health service delivery without taking in the broader priorities of the rest of the health service. We need to examine what are those facilities currently delivering and what are the actual needs of the community now and into the future, and how we reprioritise and re-strategise that for the future, and potentially standardise things a bit more too.*
>
> *For example, in the north we have lots of different district hospitals, but they all have slightly different capabilities. It all depends on historical cultural things, rather than actual frameworks or strategic plans. Getting the stakeholders in the room to talk about what is it that we think the district hospitals need to achieve for the future? What workforce do we need for that? What infrastructure? What equipment? What skills do we need and what do the patients think at the end of the day? What care are they looking for in their local community? What do they think is reasonable to be treated for in their local community and what is reasonable to seek virtual care advice for and what is reasonable to seek advice in larger hospitals?*[256]

7.26. HACSU recommended the State Government needs to undertake long term planning for health that addresses the issues of ambulance ramping in a whole of system way. This included increasing opportunities for nurse practitioners, rural generalists, and greater advocacy with the Federal Government in investment in primary health care:

> ***Mr DIGNEY*** *— What's going to solve it in the long-term and permanently, Chair, is investment in primary and community health. There are too few allied health professionals in Tasmania for the population and the general wellbeing of the population. The statistics are clear about that. There are too few general practitioners and nurse practitioners and rural generalists available in Tasmania, and because of that, what we see is members of the community become unwell to a point where they never should have got if there had been adequate primary intervention, which sees them having no other choice but to call an ambulance or present to an emergency department.*
>
> *Whilst some of that responsibility, particularly around general practitioners, sits with the federal government, it's unclear what the state is doing to pressure their federal counterparts to fix that situation. Certainly, if any government wants a long-term and lasting solution to ambulance ramping and to capacity constraints and bed block in ED, then they have to make that investment, and if they don't, then they can expect the current situation to worsen because, ultimately, sick Tasmanians have very little choice at the moment. If you are not on a GP's books or you're not already in a*

[255] Transcript of evidence, 24 January 2024, Australasian College for Emergency Medicine, pp. 9-10.
[256] Transcript of evidence, 8 November 2024, Rural Doctors Association Tasmania, p. 4.

community health service's round of patients, you're not going to get on their books or into that round and, ultimately, your condition will just get worse and worse and you'll get sicker and sicker until you end up in hospital.

……
If we can get investment into these areas and community health and primary health you'll find that there'll be less presentations to hospital and ambulances won't be having to deal with all of this chronic illness, who cannot get into a GP, who then progressively get worse and worse and then call an ambulance and end up in our EDs. When really, if they'd been able to go to a GP it could be managed sooner and they wouldn't have been sick enough for us to come and then to go to hospital.

It is a wholistic approach to health and it all has a knock-on effect. We need to look at the health system as a whole and really invest properly into that. Stop with the efficiencies and start actually investing into health.[257]

7.27. In addition to long-term planning and investment, HACSU representatives also noted that immediate solutions within district hospitals can be undertaken to relieve ambulance ramping and ED pressure:

Mr DIGNEY — *That flows into some immediate solutions, Chair, that could be considered by the government. For example, in the northern region we know that there's a ward at Scottsdale Hospital that is currently used to store beds and other equipment. We know that there are 10 acute beds available at Deloraine Hospital, but they've been shut and they've been shut for a number of years. Some of the overflow, some of the people who cause the flow issues in our larger tertiary hospitals could be moved to those rural and regional hospitals and cared for adequately there, which would free up bed space in the larger tertiary hospitals which would mean some of that blockage that we see in our EDs would be alleviated.*

Is it enough to take the entire pressure of the system? That's unclear, but there is capacity that is immediately available, as we speak, in some of those rural and regional hospitals and as I understand it, some of those rural and regional hospitals won't even take patients who are category 2. They only take category 3 and below patients, which — I'm not a clinician — so that's for someone who is far more qualified than me to make the assessment about. But I would have thought in a hospital where you have registered nurses and other registered health professionals and doctors working that they would be adequately to care for any category of patient, of course, the high acuity of patients and sick patients we'd certainly want in our larger tertiary centres, but the utilisation of rural and regional hospitals is not at 100 percent and until it is, we have to take the position that the capacity constraints relate to budgetary control measures rather than anything else.[258]

7.28. The Committee heard evidence from representatives of ACP about the high costs to the State Government when patients are treated in Emergency Departments as opposed to a primary care setting. They went on to outline the benefits of treating people in the community through mobile primary care, community health services, and extended care paramedics. They suggested this would provide more effective care, and also be more cost-effective to the State Government:

[257] Transcript of evidence, 14 December 2023, Health and Community Services Union, pp. 31-32.
[258] Transcript of evidence, 14 December 2023, Health and Community Services Union, pp. 32-33.

CHAIR *— . . .From the state Health department perspective, what is the role to step up the provision of healthcare services in the community to prevent people from ending up in ambulances and going to hospital? What is the job of the state Government? What would you recommend to them as the next steps to take?*

Mr BRUNING *— … You're right about that challenge between the federal and the state funding and where this should sit. What we see, and the data that we've looked at from the Australian Institute of Health and Welfare (AIHW) regarding hospital presentations and the cost to hospitals and the ambulance service is the state budget.*

When you have someone present to ED, it's roughly a $600 cost. When someone uses an ambulance, it's a $1000 cost, so that's $1600 every time someone gets transferred to hospital. Before you start, they go in and spend days in a bed and those sorts of things. Obviously, at this point in time, going to see a GP costs anywhere between a bulk-bill and the federal government paying about $40 to then some billing happening to the patient of another $30, $50 or $60. To see a GP is about $100.

To go through the state system in a hospital can be $1600, so if you look at the costs that the state Government have, that is the hospital and the ambulance service, if you are able to divert a small number of those people presenting to ED, whether it is walking in or via the ambulance service and treat them in the community via a mobile primary-care or mobile community health service that includes paramedics and nurses.

You have spoken about the captain there. I still think that the GP, in terms of integrated care, is that sort of captain of the healthcare team because most of us have a GP or GP clinic that we are part of if there is still some oversight there. But the cost, surely, will be lower than $1600 to treat people in their home and take care of them that way, even if it is ongoing over months. If they still present to the hospital three times per year and you were to provide ongoing care to them in their home, it is probably going to be cheaper.

You can look at it and say this is a federal government funding issue because it is primary care that is causing this issue, but you will make savings if you address it and address it in the community. It is sort of, yes, you are stuck there but I know that it will bring benefit to you, to the state budget and provide better care to the community at the same cost that you currently have.[259]

7.29. The submission by My Emergency Doctor Tasmania provided detailed recommendations about how improving telehealth capabilities in Tasmania will ease chokepoints that drive ambulance ramping:

We submit that state and federal health departments can make greater use of telehealth triage services to ease the chokepoints that are driving transfer of care delays.

As we have shown, the root causes of ToC delays are multifaceted, systemic and occur across the continuum of care, not just in EDs where their consequences ultimately manifest.

[259] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, p.12.

To adequately address them, a series of coordinated responses is required, including but not limited to:

Greater use of telehealth services (GP and emergency) in RACFs;

Greater usage of telehealth secondary triage consultation for 000 ambulance;

Greater use of telehealth triage for in-field extended care paramedics (ECPs);

Use of telehealth services for UCCs; RACFs and PHNs [primary health networks];

Use of Virtual Board Rounds in hospitals to support junior doctors and nurses overnight and on weekends to deliver better clinical and operational performance;

Use of Waiting Room services in EDs to manage T3-T5 patients[260]

7.30. The Department were questioned about their strategy to train and employ more nurse practitioners in the Tasmanian health system. The government agreed there should be more nurse practitioners but did not outline their strategy to achieve this:

Ms DOW *— We've spoken about the difficulties in primary health care across Tasmania. One of the things that's been put to us is that there is a need for nurse practitioners to play a greater role in primary health care provision across Tasmania. My question to you today is why is there no career pathway for nurse practitioners in Tasmania currently?*

….

Mr WEBSTER *— Through our outpatient transformation program we have identified pathways and identified areas where we should develop nurse practitioners. I don't have the exact details of where they are in my mind, but I am aware that the first three of those have been identified and employed in that program. The broader question might be, Ms Dow, how do you develop them for general practice and that sits in the primary care sector, which is outside the direct influence of the THS but that doesn't mean we wouldn't work on models with the federal government as we've done with GPs.*

Ms DOW *— … There doesn't appear to be clear strategy from the government or the department around introducing these roles.*

I understand that there are nurse practitioners who work in emergency departments and across the acute care sector, but I wanted to understand what the strategy was from the department's point of view of engaging more nurse practitioners?

Ms MORGAN-WICKS *— … I absolutely support whether it is a nurse practitioner, whether it is a paramedic, whether it's a pharmacist, allied health officers et cetera, what we have learnt, and perhaps the hard way through the pandemic, is that scarcity in resource and to try to make sure that we can encourage people to work to full scope of practice. We have had to be creative, particularly in some of our more remote and regional communities, to provide support…*

Mr DOCHERTY *— Another thing we want to talk about is we want to ensure that every patient gets the right care at the right place at the right time and nurse*

[260] Submission No. 63, My Emergency Doctor Tasmania, p. 10.

practitioners have an absolute role in that. Not all nurse practitioners come out that way. They have to be grown into that clear pathway and so we have to create other opportunities in the nursing career ladder… We need to do a bit more work around where they are needed in the system, but we are committed to providing more going forward. Nurse practitioners tend to be very specific in the care that they deliver and the model of care but we would love to develop far more generic nurse practitioners who have a broader scope and a broader remit in that care coordination for patients so we absolutely agree there should be more nurse practitioners. We will invest in more nurse practitioners, graduate nurse practitioners going forward. Given the scope of practice, it absolutely makes sense that patients can have absolute wraparound care from that one practitioner. It makes absolute sense.[261]

7.31. The Committee heard from ACP about how adding a Chief Paramedic Officer role to the THS Executive would improve advocacy, oversight and health care delivery, as well as emergency services' response in disasters:

Ms DOW *— … I am very interested in your recommendation 3 of introducing the role of a chief paramedic officer in Tasmania and take your point there are other senior health officer roles that provide advocacy to government and involved in health service planning. Can you elaborate on how you would see it working?*

Mr BRUNING *— Currently, we have one Chief Paramedic Officer in Australia, and that's in Victoria. They're a part time role, I think a 0.6. They work with the Chief Health Officer and the nursing and midwifery officer. That role has been in place for over six years now. The benefit we saw from that role and how it worked during COVID-19 in that all those health officers were getting together and talking about the different roles that different health professions could play in providing care to the community.*

What we saw in Victoria was paramedics used more widely and quickly than anywhere else. They were brought in to do testing and vaccinations and a whole range of things that other jurisdictions are going, hang on, paramedics just do the emergency response. We saw the impact of a chief paramedic officer to bring to bear the capabilities of a paramedic to support the health system were almost immediate. Really, they were able to save the health system some challenges by not going, 'They just sit over there in emergency response and now we're going to put a load of nurses into vaccinations and now we've not got enough nurses for other areas'.

It all had this flow on effect. They were quickly able to utilise paramedics because of that knowledge they had firsthand. There wasn't a competition between the ambulance service going hang on, I need my paramedics for this and need to meet my response times and need to do this. There was someone just sit there and say objectively, paramedics can provide this for you. We can utilise them in this way. It's not going to impact the ambulance service, so we get the best of this group of clinicians to support delivery.

I think you're unlikely to need a full-time chief paramedic officer in Tasmania, but they would be able to bring to bear the knowledge and capabilities of paramedics to the health system and make it easier for you to utilise paramedics better to service the community. A couple of years ago, we heard there was work done in Tasmania in the Health department about bringing the chief paramedic officer, but that's gone quiet

[261] Transcript of evidence, 5 February 2024, Department of Health, pp. 33 -34.

over the last two years. We thought this was going to happen for you a couple of years ago, but it's sort of gone quiet.

***Ms HAIGH** — To add to that, obviously, paramedics are involved with Health, but paramedics are also an emergency service and having a chief paramedic would not only help in Health, it would also help in emergency services, in crisis and disaster and all of those things that seem to be occurring a bit more regularly than they used to, like floods, fire, all of that sort of stuff. We get caught up in Health, but paramedics have skills in emergency response. A chief paramedic would be ideal, with a holistic approach to how paramedics can be used within the whole system, not just in health.*[262]

7.32. Mr Cameron Johnson, a paramedic, detailed in his submission many inconsistencies in, and the failure of, certain triage policy and procedures practices within ED's. He described the pressure these place on paramedics, the fact that patients are getting inconsistent care between hospitals, and the impact of transient medical staff with experience from other jurisdictions. He made a number of recommendations about how to improve this situation:

It seems that Tasmania hospitals employ a lot of transient (FIFO) medical staff who bring experiences from other jurisdictions, including different ramping processes and expectations. It needs to be clear that coercion of AT paramedic staff into commencing treatments whilst ramped is in breach of the current control measure; Clinical Management during Off Load Delay Protocol, and if this treatment is necessary, handover must occur. This is what happens in other jurisdictions, but somehow, someone at the THS (and to an extent, managers at AT) is happy to allow this breach daily, with most ramped patients.

This does differ between THS sites — for instance, the LGH Ramping Policy allows for hospital treatments to commence on ramped ambulance patients. However, this is also possibly why the LGH currently has the worst ramping statistics and longest times in the nation, and further proof that this is just making ramping worse, as it gives no incentive for ramped patients to be allocated an ED cubicle or be taken elsewhere into the hospital system.

Also, Triage-by-Diagnostics must cease — that is, making a patient an ATS Category 2, pending blood analysis and ECG (or x-ray or whatever other relevant diagnostic test is indicated). All this does is free up a Resuscitation bed that they would normally have these tests done immediately, but keeps an ambulance crew ramped for longer, because there is no real rush for the hospital staff to complete these actions and investigations urgently anymore. I have been ramped for two hours with as Category 2, only for them to go into the waiting room because the blood analysis was "ok".

Similarly, I have had sick Category 2 patients that have been ramped for two hours for Triage-by-Diagnostics, only to be confirmed as "sick" and finally handed over in a Resus Bay. These patients should be worked up in a Resuscitation Bay immediately, and transferred out as soon as it is indicated based on the science of blood gas analysis, ECG, etc.[263]

[262] Transcript of evidence, 23 January 2024, Australasian College of Paramedicine, pp. 8-9.
[263] Submission No. 38, Mr Cameron Johnson, p 13.

7.33. Mr Johnson proposed additional detailed suggestions to help increase the efficiency of patient transfer from the ramp:

> *… all ambulances could pre-notify their arrival via GRN radio or phone, to optimise off-load opportunities. If helpful, ED Navigator RN's can have ambulance arrival dashboards installed for use (some are used already in Tasmanian hospitals, however not really for priority bed allocation or planning for surge in the ED). Where the patient goes after arrival and handover is totally up to the hospital, and of no concern of the ambulance service. The hospital will find a suitable clinical space.*[264]

FINDINGS

The Committee finds:

95. A number of reviews and reports exist regarding Ambulance Tasmania, ambulance ramping, and state Emergency Department service provision. Some recommendations from these have not yet been implemented.

96. In addition to other findings of this report, the State Government has a further range of opportunities to reduce ambulance ramping that are currently not being employed:

- Consistent triage policies and procedures across Tasmanian hospitals;
- strategic review of community health centres, including infrastructure, workforce and clinical services; and
- a review of the workflow and structure of the Tasmanian Health Service.

97. In addition to other findings of this report, the State Government has opportunities to improve patient flow throughout hospitals by introducing Nurse Navigator positions in every major hospital Emergency Department and expanding this role to include discharge planning at the time of patient admission to the Emergency Department.

98. A shortage of community rapid response services, community dementia teams, and 24/7 palliative care services, are increasing pressure on hospitals.

99. Paramedics currently operate without procedures for end of shift protections.

100. The Tasmanian health system and emergency services would benefit from the establishment of a Chief Paramedic Officer.

101. There is insufficient investment in telehealth services; extended care paramedics; specialised community support teams; and secondary triage, all of which are initiatives that would help alleviate transfer of care delays.

[264] Submission No. 38, Mr Cameron Johnson, pp. 13-14.

RECOMMENDATIONS

The Committee recommends the State Government:

31. Fully implement the recommendations of the *Independent Review of Tasmania's Major Hospital Emergency Departments* within the recommended timeframes.

32. Ensures every major hospital has 24/7 Nurse Navigator positions in Emergency Departments, with this role to include discharge planning for admitted patients.

33. Substantially expand community rapid response, community dementia teams, and 24/7 palliative care services.

34. Establish a Chief Paramedic Officer position in the Tasmanian Health Service.

35. Funds the Auditor-General to undertake a reassessment of culture and leadership effectiveness within the Tasmanian Health Service.

Appendix A: List of Submissions

1. Melissa Thompson
2. Greg Dury
3. Gavin Burtt
4. Vicki Troman
5. Private witness
6. Tim Sloane
7. Private witness
8. Private witness
9. Sarah Hasler
10. Brendon Flynn
11. Peter Redman
12. Graham Williams
13. Annabel Goward
14. Johnathon Culberg
15. Jess Brennan
16. Private witness
17. Alan Butler
18. Private witness
19. Julia Earthschild
20. Private witness
21. Helen Hussey
22. Private witness
23. Dr Chris Edwards
    23a. Dr Chris Edwards
24. Rodney Jones
25. HR+ Tasmania
26. Holger Brinken
27. Kiera Kolbinski
28. Megan Cube
29. Jack Birrell
30. Margaret Cashman Bailes
31. Lynette Holland
32. Mavis Doran
33. Matthew Carew
34. Mark Nankivell
35. Peter Mulholland
36. Australian Nursing and Midwifery Federation (Tasmanian Branch)
37. Private witness
38. Cam Johnson
40. Robert Martin
41. Sandra Gaffney
42. Health Consumers Tasmania
43. Royal Hobart Hospital Emergency Department

44. Stella Jennings
45. Private witness
46. David Pittaway
47. Aspen Medical
48. Dr Virginia Watson, Dr Stuart Walker, Dr Jane Tolman and Ms Jeanette Palmer
49. Pharmaceutical Society of Australia, Tasmanian Branch
50. Australian Medical Association Tasmania
51. The Pharmacy Guild of Australia, Tasmanian Branch
52. Australasian College for Emergency Medicine
53. Health and Community Services Union
54. Australasian College of Paramedicine
55. Primary Health Tasmania
56. Toby Rowallan
57. Rural Doctors Association Tasmania
58. Robert Westland
59. Geoff Bromfield
60. Lynette Cronly
61. Martyn Goddard
62. Royal Australasian College of Physicians
63. Connected Medical Solutions Ltd.
64. Department of Health
65. Private witness
66. Private witness
67. Private witness
68. Ryan Posselt
69. Private witness
70. Royal Australian College of General Practitioners
71. Tom Millen
72. Hamish Wallace
73. Garth Faulkner
74. Dr Frank Formby

Appendix B: Minutes

MONDAY, 11 September 2023

As *Ordered*, the Committee met in Committee Room 1, Parliament House, Hobart at 1 p.m.

Members Present:

Mrs *Alexander*
Ms *Dow*
Ms *O'Byrne*
Mr *Wood*
Dr *Woodruff*
Mr *Young*

APOLOGIES

There were no apologies.

ORDER OF THE HOUSE READ

The Secretary took the Chair and read the Order of the House of Assembly appointing the Committee.

ELECTION OF COMMITTEE CHAIR

The Secretary called for nominations, Mr *Young* nominated Mrs *Alexander*, who declined the nomination.

Ms *Dow* nominated Dr *Woodruff*, who consented to the nomination.

There being no other nominations, the Secretary declared Dr *Woodruff* elected as Chair.

Dr *Woodruff* took the Chair.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations, Dr *Woodruff* nominated Ms *Dow*, who consented to the nomination.

There being no other candidates nominated, the Chair declared Ms *Dow* elected as Deputy Chair.

NOMENCLATURE

The Chair proposed two options: -

Select Committee on Transfer of Care Delays (Ambulance Ramping); or

Select Committee on Ambulance Ramping (Transfer of Care Delays)

Resolved, the Committee name be Select Committee on Transfer of Care Delays (Ambulance Ramping) (Ms *O'Byrne*)

TENTATIVE PROGRAM

The draft tentative program was discussed.

Hearing dates were discussed, and the following hearing dates were *resolved*: -

November 7th – North-West (Burnie)

November 8th – Launceston

November 9th – Hobart (Ms *Dow*)

With potential additional dates to be held for the 23rd and the morning of the 24th of November (Mrs *Alexander*).

Resolved, That the Tentative Program for the taking of evidence and the preparation, consideration, production and tabling of the Committee's report be agreed to, with the above amendments, noting that a reporting extension may be required (Dr *Woodruff*).

ADVERTISEMENT

Resolved, The draft advertisement having been previously circulated by the Secretary be agreed to and placed in the three major Tasmanian newspapers on Saturday 16th September 2023 (Dr *Woodruff*).

Resolved, that a post be published on the Parliament Facebook page for Committee members to share (Dr *Woodruff*).

Resolved, that a press release be drafted and sent to regional newspapers (Ms *O'Byrne*)

ADDITIONAL RESEARCH SUPPORT

Resolved, That unless otherwise ordered Officers of the Parliamentary Research

Service be admitted to the proceedings of the Committee whether in public or private session (Dr *Woodruff*).

Resolved, that the Parliamentary Research Service be asked to prepare a briefing paper in relation to ambulance ramping and the Inquiry's terms of reference (Dr *Woodruff*).

WITNESSES AND SUBMISSIONS TO THE COMMITTEE

Ordered, That a letter be sent to each of the following individuals and organisations seeking a submission to the Inquiry, and that the deadline for submissions be Friday, 13 October 2023: -

Australian Paramedics Association Tasmania;

Volunteer Ambulance Officers Tasmania;

Health and Community Services Union Tasmania;

Ambulance Tasmania;

Australian Medical Association;

Australasian College for Emergency Medicine; and

Australasian College of Paramedicine (Dr *Woodruff*)

National Institute of Health;

Aspen Medical;

Australian Institute of Health and Welfare;

College of Emergency Medicine; and

Hospital pharmacists; (Ms *O'Byrne*)

Australian Nursing Federation;

Royal Australian College of General Practitioners; and

Rural Doctors Association (Ms *Dow*)

Director of each hospital and of ED's;

GPTT; and

Peter Barns; (Ms *O'Byrne*)

Council Of the Aging; and

Health Consumers Tasmania; (Mrs *Alexander*)

Aged Care Tasmania; and

Primary Health Network (Ms *O'Byrne*)

Pharmacy Guild (Mr *Young*)

Federal department – re workforce demand (Ms *O'Byrne*)

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee (Ms *O'Byrne*).

PRESS STATEMENTS

Resolved, That unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members (Dr *Woodruff*).

At 1:56 p.m. the Committee adjourned until Friday, 20 *October 2023*.

Confirmed,

THURSDAY, 5 October 2023

The Committee met via WebEx, at 3:03 pm.

Members Present:

Mrs *Alexander*
Mr *Wood*
Dr *Woodruff*
Mr *Young*

APOLOGIES

Ms *O'Byrne* and Ms *Dow* were apologies.

MINUTES

The minutes of the meeting held on 11 September 2023 were read and agreed to (Mrs *Alexander*).

CORRESPONDENCE

Department of Health dated 21 September 2023:

Resolved, to accept the Departments request for an extension to the submission date until 10 November 2023 (Dr *Woodruff*).

The offer of tours of the four major hospitals was discussed and it was noted that the best time would be to try and work these tours around the November hearings.

Resolved, That the Committee accept the Department of Health Secretary's offer of tours of the four major hospitals, noting the preference for tours to coincide with the Inquiry hearings. The Secretary of the Committee to reply to the Department noting the extension has been approved, accept the offer of tours and note the potential dates (Mr *Wood*).

Royal Australasian College of Physicians and Royal Australasian College of General Practitioners - requests for submission extensions:

Resolved, to approve extensions for submissions to both the RACP and RACGP until 10 November 2023 (Dr *Woodruff*).

INQUIRY TIMELINE

Committee discussed the potential for an extension for the Committee reporting date given the extensions given to submitters, in particular the Department.

Resolved, to extend the Committee reporting date by one month (30 April 2024) with the Chair to move a motion of extension next sitting week (Dr *Woodruff*).

COMMITTEE REQUEST FOR INFORMATION – DEPARTMENT OF HEALTH

The Committee considered a list of questions provided by the Chair to be asked of the Department of Health in relation to data recorded.

Resolved, That a letter be drafted to the Tasmanian Hospital Service requesting the information outlined in the document provided by the Chair (Mrs *Alexander*).

OTHER MATTERS

The Chair raised the possibility of reopening submissions for a period of two weeks following the public hearings to capture any individuals who have perhaps ben unaware of the inquiry process. This was noted for further consideration by the Committee closer to the hearings.

The potential for using a submission portal for this purpose was also discussed should this method be available at that time.

At 3:33 p.m. the Committee adjourned until 11 a.m.

Friday 20 October 2023.

Confirmed,

FRIDAY, 20 October 2023

The Committee met in Committee room 2 and via WebEx, at 11:06 a.m.

Members Present:

Mrs *Alexander* (via WebEx)
Ms *Dow*
Ms *O'Byrne* (via WebEx)
Dr *Woodruff*
Mr *Young* (via WebEx)

APOLOGIES

Mr *Wood* was an apology.

MINUTES

The minutes of the meeting held on 5 October 2023 were read and agreed to (Mr *Young*).

SUBMISSIONS

Ordered, That the following submissions be received and published in full, with the personal contact details of individuals being removed (Dr *Woodruff*):

Submission No. 1: Melissa Thompson

Submission No. 2: Greg Drury

Submission No. 3: Gavin Burtt

Submission No. 4: Vicki Troman

Submission No. 6: Tim Sloane

Submission No. 9: Sarah Hasler

Submission No. 10: Brendon Flynn

Submission No. 11: Peter Redman

Submission No. 12: Graham Williams

Submission No. 13: Annabel Goward

Submission No. 14: Jonathan Culberg

Submission No. 15: Jess Brennan

Submission No. 17: Alan Butler

Submission No. 19: Jaiia Earthchild

Submission No. 21: Helen Hussey

Submission No. 23: Chris Edwards

Submission No. 24: Rodney Jones

Submission No. 25: HR+ Tasmania

Submission No. 26: Holger Brinkin

Submission No. 27: Kiera Kolabinski

Submission No. 28: Megan Kube

Submission No. 29: Jack Birrell

Submission No. 30: Margaret Cashman Bailes

Submission No. 31: Lynette Holland

Submission No. 32: Mavis Doran

Submission No. 33: Matthew Carew

Submission No. 34: Mark Nankivell

Submission No.35: Peter Mulholland

Submission No. 36: Australian Nursing and Midwife Federation (Tasmanian Branch)

Submission No. 38: Cam Johnson

Submission No. 39: Chris Edwards

Submission No. 40: Robert Martin

Submission No. 41: Sandra Gaffney

Submission No. 42: Health Consumers Tasmania

Submission No. 43: Emergency Department, Royal Hobart Hospital, Dr Scott

Submission No. 44: Stella Jennings

Submission No. 46: David Pittaway

Submission No. 47: Aspen Medical

Submission No. 48: Dr Watson, Dr Walker, Dr Tolman and Ms Palmer

Submission No. 49: Pharmaceutical Society of Australia

Submission No. 50: Australian Medical Association – Tasmania

Submission No. 51: Pharmacy Guild of Australia, Tasmanian Branch

Submission No. 52: Australasian College of Emergency Medicine

Submission No. 53: Health and Community Services Union

Submission No. 54: Australasian College of Paramedicine

Submission No. 55: Primary Health Tasmania

Submission No. 56: Toby Rowallan

Submission No. 57: Rural Doctors Association Tasmania

Ordered, That the following submissions be received and published with details redacted as requested by the submission authors (Ms *Dow*):

Submission No. 5: Name withheld.

Submission No. 7: Name withheld.

Submission No. 8: Name withheld.

Submission No. 16: Name withheld.

Submission No. 18: Name withheld.

Submission No. 20: Name withheld.

Submission No. 22: Name withheld.

Submission No. 37: Name withheld.

Submission No. 38: Cam Johnson.

Submission No. 45: Name withheld.

REQUEST FOR EXTENSION

The Committee considered the request for extension to submissions from COTA.

Resolved, that COTA be granted an extension for its submission until 10 November 2023 (Dr *Woodruff*).

PUBLIC HEARINGS

Witnesses to be invited to appear before the Committee were discussed.

Resolved, That the Committee hold public hearings in Burnie 7 November, Launceston 8 November and Hobart on 9, 23 and 44 November (Ms *Dow*).

Dr *Woodruff* proposed the following list of witnesses to invite to the above-mentioned hearings:

Submission No. 5: Name withheld

Submission No. 6: Tim Sloane

Submission No. 8: Name withheld

Submission No. 15: Jess Brennan

Submission No. 16: Name withheld

Submission No. 18: Name withheld

Submission No. 21: Helen Hussey

Submission No. 27: Keira Kolabinski

Submission No. 28: Megan Kube

Submission No. 29: Jack Birrell

Submission No. 31: Lynette Holland

Submission No. 32: Mavis Doran

Submission No. 33: Matthew Carew

Submission No. 35: Peter Mulholland

Submission No. 36: Australian Nursing and Midwife Foundation

Submission No. 37: Andy Healey

Submission No. 38: Cam Johnson

Submission No. 42: Health Consumers Tasmania

Submission No. 43: Dr Paul Scott

Submission No.44: Stella Jennings

Submission No. 45: Name withheld

Submission No. 46: David Pittaway

Submission No. 47: Aspen Medical

Submission No. 48: Dr Watson, Dr Walker, Dr Tolman and Ms Palmer

Submission No. 49: Pharmaceutical Society of Australia

Submission No. 50: Australian Medical Association – Tasmania

Submission No. 51: Pharmacy Guild of Australia, Tasmanian Branch

Submission No. 52: Australasian College of Emergency Medicine

Submission No. 53: Health and Community Services Union

Submission No. 54: Australasian College of Paramedicine

Submission No. 55: Primary Health Tasmania

Submission No. 56: Toby Rowallan

Submission No. 57: Rural Doctors Association Tasmania

Resolved, that Committee members review this list and get back to secretary and Committee members with comments by midday 23 October 2023. Should there be no additions, this list will be invited to appear (Ms *Dow*).

CORRESPONDENCE

The Committee considered an email from Tony Bradley requesting to appear before the Committee without a written submission.

Resolved, that Mr Bradley be invited to appear at one of the Hobart hearings (Ms *O'Byrne).*

OTHER MATTERS

Correspondence sent to the Department of Health was discussed. *Resolved*, should no response be received by Monday, that the Secretary again write to request a response (Dr *Woodruff*).

At 11:32 a.m. the Committee adjourned until Tues*day 7 November 2023*.

Confirmed,

WEDNESDAY, 8 November 2023

The Committee met at Henty House, Launceston, at 10:45 a.m.

Members Present:

Mrs *Alexander*
Mr *Behrakis*
Ms *Dow*
Ms *O'Byrne*
Mr *Wood*
Dr *Woodruff*

APOLOGIES
There were no apologies.

REOPENING OF SUBMISSIONS

The Committee agreed to the reopening of submissions to the committee inquiry until 24 November 2023 notified by media release and on the parliamentary website (Ms *O'Byrne*).

PUBLIC HEARINGS

WITNESS

At 10.59 a.m., Ms Stella Jennings was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.48 a.m. the witness withdrew.

Suspension of sitting 11.48 a.m. to 12.08 p.m.

WITNESS

At 12.08 pm, Dr Ben Dodds, President, Rural Doctors Association of Tasmania was called, made the Statutory Declaration and was examined by the Committee in public.

At 12.57 p.m. the witness withdrew.

At 12:57 p.m. the Committee adjourned until Thurs*day 9 November 2023*.

Confirmed,

THURSDAY, 9 November 2023

The Committee met in Committee room 1, Parliament House, Hobart at 9:30 a.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Mrs *Alexander*
Ms *Dow*
Ms *O'Byrne*
Mr *Wood*

APOLOGIES

There were no apologies.

PUBLIC HEARINGS

At 9.32a.m., a private witness was called, made the Statutory Declaration and was examined by the Committee in-camera.

At 10.23 a.m. the witness withdrew.

Suspension of sitting 10.23 a.m. to 10.30 a.m.

WITNESS

At 10.30 a.m., Mr David Pittaway, ED Nurse Manager, was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.23 a.m. the witness withdrew.

Suspension of sitting 11.24 a.m. to 1.29 p.m.

WITNESS

At 1.29 p.m., Mr Phil Edmondson, CEO, Primary Health Tasmania, was called, made

the Statutory Declaration and was examined by the Committee in public.

At 2.20 p.m. the witness withdrew.

PRIVATE DELIBERATION

The Committee considered other potential hearing dates.

Resolved, to schedule hearings for: -

Monday 11 December – 9 a.m. To 12 p.m.

Thursday 14 December - 11.30 a.m. To 2.30 p.m.

WITNESS

At 2.46 p.m., a private witness, was called, made the Statutory Declaration and was examined by the Committee in-camera.

At 3.20 p.m. the witness withdrew.

Mrs *Alexander* withdrew.

Suspension of sitting 3.20 p.m. To 3.24 p.m.

WITNESS

At 3 25 p.m. Dr Anette Barratt, Vice – President AMA Tasmanian and Dr Michael Lumsden Steel, AMA Board Member were called, made the Statutory Declaration and was examined by the Committee in public

At 4.03 p.m. the witnesses withdrew.

Suspension of sitting 4.03 p.m. to 4.05 p.m.

WITNESS

At 4.05 p.m. Dr Stuart Walker, Dr Jane Tolman and Ms Jeanette Palmer were called, made the Statutory Declaration and were examined by the Committee in public.

At 5.15 p.m. the witnesses withdrew.

Suspension of sitting 5.15 p.m. to 5.19 p.m.

OTHER MATTERS

Resolved, to invite before the Committee: -

Minister for Health, Hon Guy Barnett;

Ambulance Tasmania Chief Executive, Jordan Emery; and

the CEO's of the three major hospitals.

Resolved, to see if the Committee might be able to visit the Royal Hobart Hospital on Friday 24 November from 11.30 a.m.

At 5.29 p.m. the Committee adjourned until Thurs*day 23 November 2023*.

Confirmed,

MONDAY, 27 November 2023

The Committee met in Committee room 1, Parliament House, Hobart at 2:07 p.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Mrs *Alexander*
Ms *Dow*
Ms *O'Byrne*
Mr *Wood*

APOLOGIES

There were no apologies.

MINUTES

The minutes of the meeting held on 20 October, 8 November and 9 November 2023 were read and agreed to (Mrs *Alexander*).

TRANSCRIPT OF EVIDENCE

Resolved, that the transcript of evidence from the public hearings on 8 November 2023 be published (Mr *Behrakis*).

NEW SUBMISSIONS

Ordered, That the following submissions be received and published in full, with the personal contact details of individuals being removed (Dr *Woodruff*):

Submission No. 58. Robert Westland
Submission No. 59. Geoff Bromfield
Submission No. 60. Lynette Cronly

Submission No. 61. Martyn Goddard
Submission No. 62. Royal Australasian College of Physicians
Submission No. 63. My Emergency Doctor Tasmania
Submission No. 64. Department of Health
Submission No. 68. Ryan Posselt
Submission No. 70. Royal Australian College of General Practitioners
Submission No. 72. Hamish Wallace

Ordered, that the following submission be received (Dr *Woodruff*):

Submission No. 65. Anonymous

Ordered, That the following submissions be received and published with details redacted as requested by the submission authors (Ms *Dow*):

Submission No. 66: Name withheld.
Submission No. 67: Name withheld.
Submission No. 69. Name withheld.
Submission No. 71. Tom Millen

ADDITIONAL INFORMATION

Resolved, that the additional information of answers to questions from the Department of Health be published (Dr *Woodruff*).

PUBLIC HEARINGS

The Committee discussed the witnesses scheduled to appear at the next hearings of the Committee in Hobart on December 11 and 14.

Witnesses to be invited to appear before the Committee in the January hearings were discussed.

Dr *Woodruff* indicated that certain witnesses had requested to appear before the Committee in-camera. *Resolved*, to invite said witnesses to an upcoming hearing (Mrs *Alexander*).

At 2.27 p.m. Ms *Dow* joined via WebEx.

Resolved, That the Committee hold public hearings in Hobart in Hobart on 23 and 24 January 2024 (Mr *Behrakis*).

PUBLIC HEARINGS

In addition to the previously agreed to witnesses, the Committee *resolved,* to invite the following list of witnesses to invite to the above-mentioned hearings (Dr *Woodruff*):

Submission No. 60: Lynette Cronly
Submission No. 66: Name withheld
Submission No. 67: Name withheld
Submission No. 68: Ryan Possett
Submission No. 71: Tom Millen
Submission No. 72: Hamish Wallace
At 2.37 p.m. Ms *O'Byrne* joined via WebEx.

OTHER MATTERS

None.

At 2.43 p.m. the Committee adjourned until Mon*day 11 December 2023*.

Confirmed,

MONDAY, 11 December 2023

The Committee met in Committee room 1, Parliament House, Hobart at 9:01 a.m.

Members Present:

Dr *Woodruff*

Via WebEx: -
Ms *Dow*
Mr *Wood*

APOLOGIES

Mr *Behrakis was* an apology.

PUBLIC HEARINGS WITNESS

At 9.01 a.m., Mr Ryan Posselt, Ambulance Tasmania paramedic, was called, made the Statutory Declaration and was examined by the Committee in public.

At 9.15 a.m. Mrs *Alexander* joined the meeting via WebEx.

Examination of the witness continued.

At 10.00 a.m. the witness withdrew.

Suspension of sitting 10.00 a.m. to 10.04 a.m.

WITNESS

At 10.05 a.m., Mr Cameron Johnston, paramedic, was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.09 a.m. the witness withdrew.

Suspension of sitting 11.09 a.m. to 11.11 a.m.

IN-CAMERA HEARING

WITNESS

At 11.11 a.m., a private witness was called, made the Statutory Declaration and was examined by the Committee *in-camera*.

At 11.30 a.m. Mr *Wood* withdrew from the meeting.

Examination of the witness continued.

At 12.05 p.m. the witness withdrew.

OTHER MATTERS

None.

At 12.07 p.m. the Committee adjourned until Thursday *14 December 2023*.

Confirmed,

MONDAY, 14 December 2023

The Committee met in Committee room 1, Parliament House, Hobart at 11:31 a.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Mrs *Alexander*
Ms *Dow*
Mr *Wood*

APOLOGIES

Ms O'Byrne was an apology for the beginning of the session.

IN-CAMERA HEARING

WITNESS
At 11.34 a.m., a private witness, was called, made the Statutory Declaration and was examined by the Committee *in-camera*.

At 12.18 p.m. Ms *O'Byrne* join the meeting via WebEx.

Examination continued.

At 12.19 p.m. the witness withdrew.

MINUTES

Minutes of the meeting held 11 December 2023 were agreed to as an accurate record (Mr *Wood*).

TRANSCRIPTS

Resolved, that the transcript of proceedings held on 9 November be published (Ms *Dow*)

Resolved, that the public transcripts of hearings held 11 and 14 December 2023 be published when received (Ms *Dow*).

The Committee discussed the distribution on in-camera transcripts to those witnesses.

TRANSCRIPTS

Resolved, that the secretary contact the relevant witnesses to enquire if they are happy to receive transcripts via email or if they wish to disclose their mailing address to receive the transcript (Dr *Woodruff*).

Resolved, to do the same for today's witness (Dr *Woodruff*).

CORRESPONDENCE

Noted receipt of correspondence from the Department of Health dated 1 December 2023.

Resolved, that the correspondence be published (Mr *Behrakis*).

PUBLIC HEARINGS WITNESSES

At 12.36 p.m., Ms Emily Shepherd, Australian Nursing and Midwifery Foundation (ANMF), Branch Secretary, and Mr James Lloyd, Tasmanian Branch President and Ms Kylie Stubbs, ANMF Tasmania delegate, were called, made the Statutory Declaration and were examined by the Committee in public.

At 1.32 p.m. the witnesses withdrew.

Suspension of sitting 1.32 p.m. to 1.36 p.m.

WITNESSES

At 1.36 p.m., Mr Lucas Digney, Assistant State Secretary, Health and Community Services Union (HACSU) and Ms Simone Haigh, HACSU delegate, were called, made the Statutory Declaration and were examined by the Committee in public.

At 2.39 p.m. the witnesses withdrew.

OTHER MATTERS

None.

At 2.40 p.m. the Committee adjourned until Tuesday *23 January 2023*.

Confirmed,

TUESDAY, 23 JANUARY 2024

The Committee met in Committee room 1, Parliament House, Hobart at 9:00 a.m.

Members Present:

Mr *Behrakis*
Ms *Dow*
Dr *Woodruff*

Via WebEx: -
Mr *Wood*

APOLOGIES

Mrs *Alexander was* an apology. Ms *O'Byrne* was an apology until 12 p.m.

PUBLIC HEARINGS

WITNESS

At 9.05 a.m., Mr John Bruning, CEO Australasian College of Paramedicine, and Ms Simone Haigh, Board Director were called via WebEx. Ms Haigh made the Statutory Declaration and the witnesses were examined by the Committee in public.

At 9.55 a.m. the witnesses withdrew.

Suspension of sitting 9.55 a.m. to 9.59 a.m.

WITNESSES

At 10.00 a.m., Dr Paul Scott, Acting Director Emergency Department, Royal Hobart Hospital, was called, made the Statutory Declaration and was examined by the Committee in public.

At 11.03 a.m. the witnesses withdrew.

Suspension of sitting 11.03 a.m. to 12.00 p.m.

WITNESSES

At 12.00 p.m., Ms Robyn Hendry (via WebEx) General Manager, Dr Paul Dugdale, Principal Medical Advisor and Carla Skerman, Aspen Medical, were called, and examined by the Committee in public.

At 12.53 p.m. the witnesses withdrew.

Suspension of sitting 12.53 p.m. to 2.00 p.m.

WITNESS

At 2.01 p.m., Mr Hamish Wallace, was called, made the Statutory Declaration and was examined by the Committee in public.

At 2.53 p.m. the witness withdrew.

Suspension of sitting 2.53 p.m. to 2.59 p.m.

WITNESS

At 3.00 p.m., Ms Ella van Tiernan, State Manager, and Dr Shane Jackson, National Board Member, Pharmaceutical Society of Australia, were called, made the Statutory Declaration and were examined by the Committee in public.

At 3.40 p.m. the witnesses withdrew.

OTHER MATTERS

None.

At 3.42 p.m. the Committee adjourned until 9 a.m. Wednesday *24 January 2024*

Confirmed,

WEDNESDAY, 24 JANUARY 2024

The Committee met in Committee room 1, Parliament House, Hobart at 9:01 a.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Ms *Dow*
Ms *O'Byrne*
Mr *Wood*

APOLOGIES

Mrs *Alexander was* an apology.

PUBLIC HEARINGS

WITNESSES

At 9.01 a.m., Mr Bruce Levett, CEO Health Consumers Tasmania, was called, made the Statutory Declaration and was examined by the Committee in public.

At 9.52 a.m. the witnesses withdrew.

Suspension 9.52 a.m. to 10.00 a.m.

WITNESSES

At 10.00 a.m., Mr Tom Millen, registered nurse, was called, made the Statutory Declaration and were examined by the Committee in public.

At 10.51 a.m. the Committee moved *in-camera*.

At 11.00 a.m. the witnesses withdrew.

Suspension of sitting 11.00 a.m. to 11.12 a.m.

PRIVATE DELIBERATION

Correspondence -

Resolved, to receive and publish the following correspondence:

Letter from Mr Jordan Emery, Ambulance Tasmania dated 10 January 2024 (Dr *Woodruff*).

Resolved, to write to Ambulance Tasmania, requesting the following further information:

1. The protocol(s) or document(s) setting out the guidelines for staff to complete mandatory online training

2. The number of P0 and P1 cases that were unable to be immediately assigned an ambulance in the 2022/23 year, broken down by region

3. The total number of paramedic shifts worked in the 2022/23 year

4. The number of paramedic shifts that have finished within 30 minutes of the rostered finish time in the 2022/23 year

5. The average length of overtime worked per shift by paramedics in 2022/23 (e.g. 5 shifts finish on time and 1 shift finishes 30 minutes late = average overtime per shift of 5 minutes)

6. The number of paramedic shifts that would have resulted in a fully staffed roster in the Northern region on the night shift of 9 December 2023

7. The number of paramedics that worked on the night shift of 9 December 2023

8. The percentage of night shifts unfilled across the state from 1 July 2023 to 31 December 2023 (Dr *Woodruff*).

Resolved, in relation to data received by the Committee from the Department of Health, 10 November 2023, write to the Department requesting the data contained in questions 14a, 14b, 14c(1) and 14c(2) be provided in a csv file in order to use the data for analysis. Once received, seek the assistance of PRS to

analyse said data for any statistically significant correlations, as per below:

a. Between Table 14a and Table 14b – by hospital

b. Between Table 14a and Table 14c(1) – compare RHH data to the South region; LGH data to the North Region; NWRH and MCH hospital data to the NW region; and all hospitals with all regions

c. Between Table 14a and Table 14c(2) – compare RHH data to the South region; LGH data to the North Region; NWRH and MCH hospital data to the NW region; and all hospitals with all regions

d. Between Table 14b and Table 14c(1) – compare RHH data to the South region; LGH data to the North Region; NWRH and MCH hospital data to the NW region; and all hospitals with all regions

e. Between Table 14b and Table 14c(2) – compare RHH data to the South region; LGH data to the North Region; NWRH and MCH hospital data to the NW region; and all hospitals with all regions (Mr *Wood*).

Additional information: -

Resolved, that the additional information provided in hearings by HACSU and Cam Johnson be noted and published (Mr *Behrakis*).

Hearing transcripts: -

Resolved, that the transcripts of the hearings of 23 and 24 January 2024 be published when available (Mr *Behrakis*).

Resolved, that the in-camera transcript be sent to the private witness of 24 January 2024 (Dr *Woodruff*).

Hearing dates: -

Resolved, a hearing be held with Ambulance Tasmania and the Department of Health representatives on 5 February 2024, 1.30 p.m. to 4.30 p.m. (Ms Dow).

Resolved, that the secretary write to the Minister for Health inviting him to attend a hearing on one of the three following dates/times: -

- 4.30 p.m. on 5 February 2024;
- 3 p.m. on 8 February 2024; or
- 3 p.m. on 8 February 2024; (Dr *Woodruff*).

The Committee considered a request for an appearance before the Committee by a Dr Formby. *Resolved*, that the secretary respond to Dr Formby requesting he provide the Committee with a written submission (Ms *Dow*).

The Committee discussed possible times to invite Ms Duncan to appear as a witness.

The Committee considered the evidence of Mr Millen. *Resolved*, to seek advice from the Clerk on how to deal with the information provided in relation to possible criminal allegations before contacting the individual Mr Millen said could supply additional information (Dr *Woodruff*).

The Committee discussed the meeting dates for the consideration of the report of the Committee, noting March 19, 20 and 21 had been set aside. Noted, that should the Committee require an extension to the Reporting date, it can do so during the week of 9 April 2024.

WITNESSES

At 12.00 p.m., Ms Katie Hayes, Branch committee member and pharmacist, the Pharmacy Guild, was called, made the Statutory Declaration and was examined by the Committee in public.

At 12.34 p.m. the witness withdrew.

Suspension of sitting 12.35 p.m. to 2.04 p.m.

WITNESS

At 2.06 p.m., Dr Juan Carlos Ascencio-Lane, Tasmanian Chair, and Hamish Bourne, Policy and Advocacy Manager, Australasian College

of Emergency Medicine, were called, made the Statutory Declaration and were examined by the Committee in public.

At 2.13 p.m. *Ms O'Byrne* joined the meeting.

Examination continued.

At 2.53 p.m. the witnesses withdrew.

Suspension of sitting 2.53 p.m. to 3.02 p.m.

PRIVATE WITNESS

IN-CAMERA

At 3.02 p.m., a private witness was called, made the Statutory Declaration and was examined by the Committee in-camera.

At 3.35 p.m. Ms *Dow* Withdrew.

Examination continued.

At 3.50 p.m. the witness withdrew.

Suspension of sitting 3.51 p.m. 4.00 p.m.

PUBLIC HEARING WITNESS

At 4.02 p.m., Mr Toby Rowallan, ambulance dispatcher was called, made the Statutory Declaration and was examined by the Committee in-camera.

At 4.51 p.m. the witness withdrew.

OTHER MATTERS

None.

At 4.52 p.m. the Committee adjourned until Monday 5 *February 2024*.

Confirmed,

MONDAY, 5 FEBRUARY 2024

The Committee met in Committee Room 1, Parliament House, Hobart at 1:30 p.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Ms *Dow*
Mr *Wood*
Mrs *Alexander*

APOLOGIES

Ms O'Byrne was an apology.

PUBLIC HEARING WITNESSES

At 1.32 p.m., the following witnesses, were called, made the Statutory Declaration and were examined by the Committee in public:

- Jordan Emery - Chief Executive, Ambulance Tasmania
- Kathrine Morgan-Wicks - Secretary
- Dale Webster - Deputy Secretary, Community Mental Health & Wellbeing
- Laura Pyszkowski – Acting Director, Office of the Secretary

At 2.37 p.m. the witnesses withdrew.

Suspension of sitting 2.37 p.m. to 2.40 p.m.

WITNESSES

At 2.41 p.m., the following witnesses, were called, made the Statutory Declaration and were examined by the Committee in public:

- Brendan Docherty - Deputy Secretary, Hospitals and Primary Care
- Fiona Lieutier - Chief Executive, Hospitals North
- Joe McDonald - Chief Executive, Hospitals South

At 2.41 p.m., the following witnesses were recalled:

- Kathrine Morgan-Wicks - Secretary
- Dale Webster - Deputy Secretary, Community Mental Health & Wellbeing
- Laura Pyszkowski – Acting Director, Office of the Secretary

WITNESSES

At 4.05 p.m., Jordan Emery, Chief Executive, Ambulance Tasmania, was recalled.

At 4.06 p.m., Mr Emery withdrew.

At 4.40 p.m. the witnesses withdrew.

OTHER MATTERS

Resolved, that the Committee conduct hearings on 6 February 2024 at 9.00 a.m., and 8 February 2024 at 3.00 p.m., to hear evidence from Amanda Duncan and the Minister for Health, respectively. (Mr *Behrakis*)

At 4.46 p.m. the Committee adjourned until 9.00 a.m., Tuesday 6 *February 2024*.

Confirmed,

Tuesday, 6 FEBRUARY 2024

The Committee met in Committee Room 2, Parliament House, Hobart at 9:02 a.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Ms *Dow*
Mr *Wood*
Ms O'Byrne

APOLOGIES

Mrs *Alexander was* an apology.

PUBLIC HEARINGS

WITNESSES

At 9.04 a.m., Ms Amanda Duncan, was called, made the Statutory Declaration and was examined by the Committee in public.

Suspension of sitting 10.16 a.m. to 10.17 a.m.

At 10.18 a.m., the hearing was closed to the public and Ms Duncan was examined by the Committee *in camera*.

Ms Duncan tabled 10 documents that she requested remain confidential.

At 10.36 a.m. the witness withdrew.

Resolved, that the documents tabled by Ms Duncan be received but remain confidential for Committee Members only and are not to be made public or be published. (Ms *Woodruff*).

At 10.38 a.m. the Committee adjourned until 3.00 p.m., Thursday *8 February 2024*.

Confirmed,

Thursday, 8 FEBRUARY 2024

The Committee met in Committee Room 1, Parliament House, Hobart at 3:00 p.m.

Members Present:

Mr *Behrakis*
Dr *Woodruff*

Via WebEx: -
Ms *Dow*
Mr *Wood*

Mrs *Alexander*

Ms O'Byrne

APOLOGIES

There were no apologies.

PUBLIC HEARING WITNESSES

At 3.00 p.m., the Minster for Health, the Hon *Guy Barnett* MP was called and examined by the Committee in public.

The Minister for Health tabled the following letters:

- Letter dated 7 February 2024 from Leader of the Tasmanian Greens, Dr Rosalie Woodruff MP, to the Minister for Health, the Hon Guy Barnett MP, regarding allegations raised at recent hearings of the Select Committee on the Transfer of Care about a former senior manager at the Launceston General Hospital
- Letter from the Minister Health (undated) in response to the letter from Dr Woodruff MP of 7 February 2024.

At 3.37 p.m., Kathrine Morgan-Wicks, was recalled, and examined by the Committee in public:

The Minister for Health tabled the following document:

- Tasmanian Health Service Protocol – Death of a Patient (including Coroners Notification)

The Minister for Health tabled the following document:

- Percentage of GP Patients in each state/territory who are always are bulk-billed.

PUBLIC HEARING

WITNESSES

The Minister for Health took the following questions on notice:

- The number of full-time equivalent paramedics (total FTE, including both permanent employees and those on fixed term contracts) employed at the start of the last financial year, as of today, as of next week, and what are the projected number of paramedics planned to be employed by July of this year.
- The number of physical beds in regional health facilities that are not open and not currently staffed.

At 4.18 p.m. the witnesses withdrew.

Suspension of sitting 4.18 p.m. to 4.20 p.m.

CONSIDERATION OF MS DUNCAN'S EVIDENCE

Resolved, that the Committee take the following actions:

- Send cover letter and Hansard transcript of Amanda Duncan's (AD) public evidence to the following bodies as an fyi, stating that instances of misconduct or illegal activity have been alleged (and may require investigation):
    - Minister for Health
    - Tas Police
    - Health Complaints Commissioner
    - AHPRA (Australian Health Practitioner Regulation Agency
    - The federal/national Health Facility/Hospital Accreditation body (Australian Commission on Safety and Quality in Health Care?)
- In relation to AD's confidential tabled documents, Secretary to check these to see what may possibly be of use in providing, on a confidential basis, to the above authorities to assist them in any investigation they may conduct.
- Contact the authorities above and have them provide guidelines/protocols on how they deal with information that has been confidentially given to the Committee and is passed on to them to assist in their investigations, including how they can commit to maintaining AD's confidentiality.
- If sufficient assurance/comfort is received from these authorities as to keeping the confidentiality attached to AD's documents, then contact AD to ask her permission for the Committee to provide the relevant confidential documents to these authorities on a confidential basis. Confidential documents are only to be provided to these authorities if AD provides express permission. (Mr *Behrakis*)

OTHER BUSINESS

Resolved, that the Committee receive a late submission (Mr *Behrakis*)

Resolved, that the Committee write to the Secretary, Department of Health, Ms Kathrine Morgan-Wicks, to seek clarification that if Committee members receive requests

from anyone who wishes to provide additional information in relation to AD's evidence, she is the appropriate point of contact to refer people to. (Dr *Woodruff*)

At 4.38 p.m. the Committee adjourned *sine die*.

Confirmed,

WEDNESDAY, 26 JUNE 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 3.30 p.m.

Members Present:

In person:
Dr *Woodruff*
Ms *Johnston*

Via Webex:
Ms *Haddad*
Mr *Wood*
Mr *Behrakis*
Ms *Dow*

APOLOGIES

There were no apologies.

ORDER OF THE HOUSE READ

The Secretary took the Chair and read the Order of the House of Assembly appointing the Committee.

ELECTION OF CHAIR

The Secretary called for nominations, *Dr Woodruff* nominated *Ms Johnston*, who consented to the nomination.

There being no other nominations, the Secretary declared *Dr Woodruff* elected as Chair.

Dr Woodruff took the Chair.

ELECTION OF DEPUTY CHAIR

The Chair called for nominations, *Ms Dow* nominated *Ms Haddad*, who consented to the nomination.

There being no other candidates nominated, the Chair declared *Ms Haddad* elected as Deputy Chair.

WORK OF PREVIOUS COMMITTEE TO BE RECEIVED

Resolved that the transcripts, submissions, papers and any other evidence of the Select Committee on Transfer of Care Delays of the 50th Parliament be received by this Committee for its consideration *(Ms Johnston)*.

ADDITIONAL RESEARCH SUPPORT

Resolved, That unless otherwise ordered Officers of the Parliamentary Research Service be admitted to the proceedings of the Committee whether in public or private session *(Dr Woodruff)*.

CHAIR TO BE THE SPOKESPERSON

Resolved, That the Chair be the spokesperson in relation to the operations of the Committee *(Dr Woodruff)*.

PRESS STATEMENTS

Resolved, That unless otherwise ordered, press statements on behalf of the Committee be made only by the Chair after approval in principle by the Committee or after consultation with Committee Members *(Dr Woodruff)*.

MINUTES

Members to be provided previous minutes. Vote to accept minutes to take place at next meeting.

In-camera hearing testimony to be distributed to *Ms Haddad* and *Ms Johnston*.

COMMITTEE WORKPLAN

At 4:30 p.m. the Committee adjourned until Monday, 26th August 2024.

Confirmed,

WEDNESDAY, 27 AUGUST 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 9.32 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Dow*
Ms *Haddad* (Deputy Chair)
Ms *Johnston*
Mr *Wood*

APOLOGIES

There were no apologies.

MINUTES
The minutes of the meeting held 26 June 2024 were agreed to (Mr *Behrakis*).

EXTENSION OF REPORTING DATE

Resolved, that the Committee move a motion on September 10, 2024, to extend the Committee reporting date to Thursday October 17, 2024.

ADDITIONAL MEETING DATES – CONSIDERATION OF REPORT

Resolved, that the Committee meet for further consideration of the draft reports on:

- Thursday, October 3, 2024
- Wednesday, October 9, 2024, and
- Thursday, October 10, 2024.

At 9.44 a.m. Ms *Dow* joined the meeting.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

Chapter 1: -

Paragraphs 1.1 to 1.11 agreed to.

Paragraph 1.12 agreed to as amended.

Paragraphs 1.13 to 1.17 agreed to.

Paragraph 1.8 postponed.

Paragraphs 1.19 and 1.20 agreed to.

Chapter 2: -

Paragraphs 2.1 to 2.3 agreed to.

Paragraphs 2.4 and 2.5 agreed to as amended.

Paragraph 2.6 agreed to.

Paragraph 2.7, as amended, to be moved to Chapter 3.

New paragraph 2.7 – note to be placed in footnote re Submission 37 being anonymous.

Paragraph 2.8 – Amendment proposed – That the evidence of DoH to be split into two paragraphs. Paragraph as amended agreed to.

Paragraph 2.11 as amended, agreed to.

Paragraph 2.10 agreed to as amended.

Paragraph 2.11 agreed to as amended.

Paragraphs 2.13 to 2.16 agreed to.

Paragraph 2.17 agreed to as amended.

Paragraph 2.18 agreed to as amended.

Paragraph 2.19 agreed to as amended.

Paragraph 2.20 and 2.21 agreed to.

Paragraph 2.22 and 2.23 agreed to amended.

Paragraph 2.24 deleted.

Findings of this section considered and amended. Resolved, to return to the findings after progressing though the report.

At 12.08 p.m. Ms *Dow* left the meeting.

Findings of this section further considered and amended.

Suspension of sitting 12.22 p.m. to 1.16 p.m.

Members present:

In person:
Mr *Behrakis*

Dr *Woodruff* (Chair)

Via Webex:
Ms *Dow*
Mr *Wood*

Paragraphs 2.26 and 2.27 agreed to.

At 1.20 p.m. Ms *Johnston* returned to the meeting via Webex.

Paragraph 2.28 agreed to as amended.

Paragraph 2.29 agreed to as amended.

Paragraph 2.30 agreed to as amended.

Findings considered.

At 1.41 p.m. Ms *Dow* returned to the meeting via WebEx.

Paragraph 2.31 agreed to.

Paragraph 2.32 agreed to as amended.

Paragraphs 2.33 to 2.35 agreed to.

Paragraph 2.36 agreed to as amended.

Paragraph 2.37 moved to under paragraph 2.35.

Paragraph 2.38 agreed to as amended.

Paragraph 2.33 and 2.34 moved to below paragraph 2.41.

New paragraph 2.38 agreed to as amended.

New paragraph 2.38 agreed to as amended.

Findings considered and amended.

Paragraph 2.42 agreed to.

Paragraph 2.23 agreed to as amended.

Paragraph 2.44 agreed to as amended.

Paragraphs 2.45 and 2.46 agreed to.

Findings considered and amended.

At 3.39 p.m. Ms *Johnston* left the meeting.

Suspension of sitting 3.40 p.m. to 3.57 p.m.

Members present:

In person:

Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Mr *Wood*

Paragraphs 2.48 and 2.49 agreed to.

Ms *Johnston* joined via WebEx at 3.59 p.m.

Paragraph 2.50 agreed to as amended.

Paragraph 2.51 moved to under 2.41.

Findings considered and amended.

Paragraphs 2.53 and 2.54 agreed to as amended.

Paragraph 2.55 moved to 2.21.

ANY OTHER MATTERS
None.

At 4:54 p.m. the Committee adjourned until Thursday, 28th August 2024.

Confirmed,

THURSDAY, 28 AUGUST 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 9.34 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Dow*
Ms *Johnston*
Mr *Wood*

APOLOGIES
Ms *Haddad* was an apology for the morning.

CONSIDERATION OF CHAIR'S DRAFT REPORT
The Committee considered the Chair's draft report.

Chapter 2: - continued

Paragraphs 2.54 to 2.64 agreed to as amended.

Paragraph 2.62 moved to below former paragraph 2.58.

Paragraph 2.66 agreed to as amended.

Suspension of sitting from 11.19 a.m. to 11.30 a.m.

Paragraph 2.67 removed.

New paragraph 2.67 agreed to as amended.

New paragraph 2.67 amended and moved below former paragraph 2.58.

Paragraphs 2.69 and 2.70 removed.

Findings considered and amended.

Suspension of sitting 12.20 p.m. to 1.34 p.m.

Members Present:

In person:
Dr *Woodruff* (Chair)

Via Webex:
Ms Haddad
Ms *Johnston*
Mr *Wood*

Findings further considered and amended.

At 1.52 p.m. Ms Dow rejoined the meeting via WebEx.

Findings further considered and amended.

Resolved, to return to the Committee recommendations for this chapter at a later time.

Resolved, that Chapter 2, as amended, be agreed to (Mr Wood)

Chapter 3: -

Paragraphs 3.1 to 3.7 agreed to.

At 2.49 p.m. Ms *Wood* left the meeting.

Paragraphs 3.8 and 3.9 agreed to as amended.

Paragraphs 3.10 to 3.14 agreed to.

Paragraphs 3.15 to 3.20 agreed to as amended.

Findings considered and amended.

Suspension of sitting from 3.40 p.m. to 3.58 p.m.

Members Present:

In person:
Dr *Woodruff* (Chair)

Via Webex:
Ms *Dow*
Ms Haddad
Ms *Johnston*

Findings further considered and amended.

New paragraph 3.3 inserted.

Paragraphs 3.23 to 3.25 agreed to.

Paragraph 3.26 agreed to as amended.

Paragraph 3.27 agreed to.

Paragraphs 3.28 and 3.29 agreed to as amended.

At 4.33 p.m. Mr Behrakis rejoined the meeting in person.

Paragraphs 3.29 to 3.34 agreed to as amended.

Paragraph 3.35 removed.

ANY OTHER MATTERS

Noted the previous resolution to move an extension to the reporting date on 10 September 2024.

At 5:02 p.m. the Committee adjourned until Thursday, 3 October 2024.

Confirmed,

THURSDAY, 3 OCTOBER 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 9.34 a.m.

Members Present:

In person:

Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Ms *Johnston*
Mr *Wood*

APOLOGIES

Ms *Dow* was an apology.

MINUTES

The minutes of the meetings held 27 August 2024 and 28 August 2024 were agreed to (Mr *Behrakis*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

Chapter 3: - continued

Paragraph 3.35 agreed to as amended.

Findings considered and amended.

Paragraphs 3.36 to 3.39 agreed to as amended.

New paragraph 3.40 (former paragraph 3.41) moved before former paragraph 3.40 and agreed to as amended.

New paragraph 3.41 inserted and agreed to.

New Paragraph 3.42 (former paragraph 3.40) agreed to as amended.

New paragraph 3.43, created from final section of former paragraph 3.40, agreed to as inserted.

New paragraph 3. 44 (former paragraph 3.43) agreed to as moved and amended.

New paragraphs 3.45 and 3.46 (former paragraph 3.42) split and agreed to as amended.

New paragraph 3.47 (former paragraph 3.44) agreed to as amended.

New paragraph 3. 48 (former paragraph 3.45) agreed to as amended.

New paragraph 3.49 (former paragraph 3.46) agreed to as amended.

Suspension of sitting from 11.26 a.m. to 11.39 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Ms *Johnston*
Mr *Wood*

New paragraph 3.50 (moved former paragraph 3.51) agreed to as amended.

New paragraph 3.51 (moved former paragraph 3.57) agreed to as amended.

New paragraph 3.52 (former paragraph 3.47) agreed to as amended.

New paragraph 3. 53 (former paragraph 3.48) agreed to as amended.

Insert new paragraph 3.54 (pulled from former paragraph 3.51) agreed to as amended.

New paragraph 3. 55 (former paragraph 3.49) agreed to as amended.

New paragraph 3.56 (former paragraph 3.50) agreed to as amended.

New paragraph 3.57 (former paragraph 3.68) moved and agreed to as amended.

New paragraph 3.58 (former paragraph 3. 52) agreed to as amended.

New paragraph 3.59 (former paragraph 3. 53) split and agreed to as amended.

Final section of former paragraph 3.53 from 'my emergency' to 'takes us 25.5 hours' moved to follow existing paragraph 2.16. Therefore, new paragraph 2.17 agreed to as amended.

New paragraph 3.60 (former paragraph 3.54) agreed to as amended.

New paragraph 3.61 (former paragraph 3.55) agreed to as amended.

Agreed to remove former paragraph 3.56.

New paragraph 3.62 (former paragraph 3.57) agreed to as amended.

Suspension of sitting from 12.50 p.m. – 1. 52 p.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Johnston*
Mr *Wood*

New paragraph 3.63 (former paragraph 3.59) agreed to as amended.

Ms *Haddad* joined the meeting via WebEx at 1.55 p.m.

New paragraph 3.64 (former paragraph 3.60) agreed to as amended.

Findings considered and amended.

Subchapter title – amendment to replace the former title 'Emergency Department and other Hospital Functions' with 'Impact on Emergency Department Functions.' Title, as amended, agreed to.

New paragraph 3.65 (former paragraph 3.61) agreed to as amended.

New paragraph 3.66 (former paragraph 3.62) agreed to.

New paragraph 3.67 (former paragraph 3.63) agreed to as amended.

New paragraph 3.68 (former paragraph 3.64) agreed to as amended.

New paragraph 3.69 (former paragraph 3.65) agreed to as amended.

New paragraph 3.70 (former paragraph 3.66) agreed to as amended.

New paragraph 3. 71 (former paragraph 3.67) agreed to as amended.

Former paragraph 3.68 moved to new paragraph 3.57.

New paragraph 3.72 (former paragraph 3.69) agreed to as amended.

Findings considered and amended.

Mr *Behrakis* left the table at 3.42 p.m. and returned at 3. 45 p.m.

Considerations and amended of findings continued and concluded.

Noted that additional draft findings remain in this section that the Committee has not amended.

Resolved, that Chapter 3, as amended, be agreed to (Dr *Woodruff*).

Suspension of sitting from 3. 54 p.m. – 4.01 p.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Ms *Johnston*
Mr *Wood*

Chapter 4: - considered

Paragraph 4. 1 as amended agreed to.

Paragraph 4.2 agreed to.

Paragraph 4.3 as amended agreed to.

Paragraph 4.4 agreed to.

Paragraphs 4.7 – 4.9 as amended agreed to.

Agreed to remove former paragraph 4.10.

New paragraph 4.10 and 4.11 as amended agreed to.

Findings to be discussed at next meeting.

ANY OTHER MATTERS

Resolved, that in each chapter and subchapter of the report, acronyms be defined in full (including names of organisations) at their first use and witnesses be introduced in full at their first use. Common acronyms such as Emergency Department (ED) do not have to be restated (Ms *Haddad*).

Noted that the Committee Secretariat will investigate options to streamline intext referencing used from submissions.

At 4:34 p.m. the Committee adjourned until Wednesday, 9 October 2024.

Confirmed,

WEDNESDAY, 9 OCTOBER 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 9.37 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*

Mr *Wood*

APOLOGIES

There were no apologies.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

Chapter 4: -

Findings considered.

Chapter 5: -

Paragraph 5.1 and 5.2 agreed to as amended.

Paragraph 5.3 to 5.9 agreed to.

Paragraph 5.10 agreed to as amended.

Paragraph 5.11 and 5.12 agreed to.

Paragraph 5.13 to 5.15 agreed to as amended.

Paragraph 5.16 to 5.19 agreed to.

Paragraph 5.20 considered.

At 10.17 a.m. Ms *Dow* joined via WebEx.

Paragraph 5.20 further considered.

At 10.17 a.m. Ms *Johnston* joined via WebEx.

Paragraph 5.20 agreed to as amended.

Paragraph 5.21 to 5.28 agreed to as amended.

Ms Dow left the meeting at 11.04 a.m.

New paragraph 5.29 (former paragraph 5.28(2)) agreed to as amended.

New paragraph 5.30 (former paragraph 5.29) agreed to as amended.

New paragraph 5.31 (former paragraph 5.30) agreed to as amended.

New paragraph 5.32 (former paragraph 5.31) agreed to as amended.

New paragraph 5.33 (former paragraph 5.32) agreed to as amended.

Insert new paragraph 5.34, agreed to as amended.

Suspension of sitting from 11.33 a.m. to 11.45 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Ms *Johnston*
Mr *Wood*

New paragraph 5.35 (former paragraph 5.33) agreed to as amended.

New paragraph 5.36 (former paragraph 5.34) agreed to as amended.

Insert new paragraph 5.37, agreed to as amended.

New paragraph 5.38 (former paragraph 5.35) agreed to as amended.

Findings considered and amended.

Resolved, that Chapter 5, as amended, be agreed to (Dr *Woodruff*).

Suspension of sitting from 12.50 a.m. to 1.37 p.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Haddad*
Mr *Wood*

Chapter 6: -

Chapter 6 title amended and agreed to.

Paragraph 6.1 agreed to.

Paragraph 6.2 to 6.9 agreed to as amended.

Paragraph 6.10 agreed to.

At 2.14 p.m. Ms *Johnston* joined the meeting via WebEx.

Findings considered and amended.

At 2.18 p.m. Ms *Dow* joined the meeting via WebEx.

Findings further considered and amended.

Resolved, that Chapter 6, as amended be agreed to.

Chapter 7: -

Paragraph 7.1 agreed to as amended.

Paragraph 7.2 to 7.5 agreed to.

Paragraph 7.6 to 7.8 agreed to as amended.

Paragraph 7.9 deleted.

Paragraph 7.9 (former paragraph 7.10) agreed to.

Paragraph 7.10 (former paragraph 7.11) agreed to as amended.

Paragraph A deleted.

Paragraph 7.11 (former paragraph B) agreed to as amended.

Paragraph 7.12 (former paragraph C) considered.

At 3.30 p.m. Mr *Behrakis* left the Table.

Paragraph 7.12 (former paragraph C) agreed to as amended.

Paragraph 7.13 (former paragraph D) agreed to as amended.

Paragraph 7.14 (former paragraph E) agreed to as amended.

Paragraph 7.15 (former paragraph F) agreed to as amended.

Paragraph 7.16 (former paragraph G) agreed to as amended.

Paragraph 7.17 (former paragraph H) agreed to as amended.

Paragraph 7.18 (former paragraph I) agreed to as amended.

Paragraph 7.19 (former paragraph J) agreed to as amended.

Paragraph 7.20 (former paragraph K) agreed to as amended.

Paragraph 7.21 (former paragraph L) agreed to as amended.

Paragraph 7.22 (former paragraph M) deleted.

Paragraph 7.23 (former paragraph N) agreed to as amended.

Paragraph 7.24 (former paragraph O) agreed to as amended.

Paragraph O considered.

At 4.34 p.m. the Committee adjourned until Thursday, 10 October 2024.

Confirmed,

THURSDAY, 10 OCTOBER 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 9.36 a.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Johnston*
Ms Dow

APOLOGIES

Ms *Haddad* was an apology.

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

At 9.39 a.m. Mr *Wood* joined via Webex.

Paragraph 7.24 (former paragraph O) agreed to as amended.

Paragraph 7.25 (former paragraph P) agreed to as amended.

Paragraph 7.26 (former paragraph Q) agreed to as amended.

Paragraph 7.27 (former paragraph R) agreed to as amended.

Paragraph 7.28 (former paragraph S) agreed to as amended.

Paragraph 7.29 (former paragraph T) agreed to as amended.

Paragraph U deleted.

Paragraph 7.30 (new paragraph U) agreed to as amended.

Paragraph W deleted.

Paragraph 7.31 (former paragraph X) agreed to as amended.

Paragraph 7.32 (former paragraph Y) agreed to as amended.

Paragraph 7.33 (former paragraph Z) agreed to as amended.

Paragraph AA deleted.

Paragraph BB deleted.

Chapter 7, findings considered and amended.

Suspension of sitting from 11:53 am to 12:11 pm.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Johnston*

Mr *Wood*

Chapter 7, findings further considered and amended.

At 12.17 p.m. Ms *Dow* joined the meeting via WebEx.

Consideration and amendment of Chapter 7 findings continued.

Suspension of sitting from 12:45 a.m. to 1:32 p.m.

Members Present:

In person:
Mr *Behrakis*
Dr *Woodruff* (Chair)

Via Webex:
Ms *Johnston*
Mr *Wood*
Ms Dow

Consideration of the Chairs report continued.

Major findings - page 5, considered.

Major finding 1 agreed to.

Major finding 2 agreed to.

Major finding 3 agreed to.

Major finding 4 amended and agreed to.

Major finding 5 agreed to.

Major finding 6 agreed to.

Major finding 7 read

And the Question being put – That Major Finding 7 be agreed to.

The Committee divided.

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Major finding 8 read.

And the Question being put – That Major Finding 8 be agreed to.

The Committee divided.

Ayes	Noes
Ms *Dow*	Mr Behrakis
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Major finding 9 agreed to as amended.

Detailed findings considered.

Chapter 1 – Context and Causes:

Finding 1 amended and agreed to.

Finding 2 agreed to as amended.

Finding 3 agreed to.

Finding 4 deleted.

Finding 5 deleted.

Chapter 2 – Access Block:

Finding 4 (former finding 6) agreed to.

Finding 5 (former finding 7) agreed to.

Finding 6 (former finding 8) amended and agreed to.

Former findings 9 and 10 deleted.

Finding 7 (former finding 11) agreed to as amended.

Capacity and flow:

Finding 8 (Former finding 12) agreed to.

Finding 9 (Former finding 13) agreed to.

Finding 10 (Former finding 14) agreed to.

Finding 11(Former finding 15) agreed to.

Finding 12 (Former finding 16) agreed to as amended.

Exit block:

Finding 13 (Former finding 17) agreed to.

Finding 14 (Former finding 18) agreed to as amended.

Finding 15 (Former finding 19) agreed to as amended.

Finding 16 (Former finding 20) agreed to as amended.

Finding 17 (Former finding 21) agreed to as amended.

Finding 18 (Former finding 22) agreed to as amended.

Finding 19 (Former finding 23) agreed to.

Former finding 24 deleted.

Staff shortages:

Finding 20 (Former finding 25) agreed to as amended.

Former finding 26 and 27 deleted.

Finding 21 (Former finding 28) agreed to.

Finding 22 (Former finding 29) agreed to.

Finding 23 (Former finding 30) agreed to.

Finding 24 (Former finding 31) agreed to as amended.

Heading amended from 'Funding' to 'Resourcing'.

Finding 25 (Former finding 32) read.

And the Question being put – That Finding 25 be agreed to.

The Committee divided

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Finding 26 (Former finding 33) agreed to as amended.

Finding 27 (Former finding 34) and finding 28 (35) read.

And the Question being put – That Finding 27 and 28 be agreed to.

The Committee divided

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Primary and community care:

Finding 29 (Former finding 36) agreed to as amended.

Finding 30 (Former finding 37) agreed to as amended.

Finding 31 (Former finding 38) agreed to as amended.

Finding 32 (Former finding 39) and Finding 33 (Former finding 40) agreed to.

Finding 34 (Former finding 41) agreed to as amended.

Finding 35 (Former finding 42) agreed to.

Finding 36 (Former finding 43) agreed to as amended.

Finding 37 (Former finding 44), finding 38 (Former finding 45) and finding 39 (Former finding 46) agreed to.

Finding 40 (Former finding 47) agreed to as amended.

Finding 41 (Former finding 48) agreed to as amended.

Heading amended from 'Effect of Transfer of Care Delays on patient Care' to 'Effect of Ambulance Ramping'.

Finding 42 (Former finding 49) agreed to as amended.

Finding 43 (Former finding 50) agreed to.

Finding 44 (Former finding 51) agreed to as amended.

Former finding 52 deleted.

At 2.46 p.m., Mr *Wood* left the meeting.

Finding 45 (Former finding 53) agreed to as amended.

Finding 46 (Former finding 54) agreed to as amended.

Finding 47 (Former finding 55) agreed to as amended.

Finding 48 (Former finding 56) agreed to as amended.

Finding 49 (Former finding 57) considered.

At 2.54 p.m. Mr *Wood* joined the meeting via WebEx.

Finding 49 further considered and agreed to as amended.

Ambulance response:

Finding 50 (Former finding 58) agreed to as amended.

Finding 51 (Former finding 59) agreed to.

Finding 52 (Former finding 60) agreed to.

Finding 53 (Former finding 61) agreed to as amended.

Finding 54 (Former finding 62) agreed to.

Finding 55 (Former finding 63) agreed to as amended.

Finding 56 (Former finding 64) agreed to.

Finding 57 (Former finding 65) agreed to as amended.

Wellbeing of staff:

Finding 58 (Former finding 66) agreed to as amended.

Finding 59 (Former finding 67) agreed to as amended.

Finding 60 (Former finding 68) agreed to as amended.

Finding 61 (Former finding 69) agreed to.

Finding 62 (Former finding 70) agreed to as amended.

Finding 63 (Former finding 71) agreed to.

Finding 64 (Former finding 72) agreed to.

Finding 65 (Former finding 73) read.

And the Question being put – That Finding 65 be agreed to.

The Committee divided

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Impact on Emergency Department functions:

Finding 66 to 69 agreed to as amended.

Finding 70 agreed to.

Finding 71 agreed to as amended.

New finding 72 added and agreed to.

New finding 72 moved to page55.

Chapter 4 data:

Findings 75 to 79 agreed to.

Finding 80 deleted.

Chapter 5 – Government response

Former finding 68 deleted.

Former finding 62 read.

And the Question being proposed – That Finding 62 be agreed to

The Committee divided.

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Former finding 63 and 64 agreed to.

Former finding 65 read.

And the Question being proposed – That Finding 63 be agreed to

The Committee divided.

Ayes	Noes
Ms *Dow*	Mr *Behrakis*
Ms *Johnston*	Mr *Wood*
Dr *Woodruff*	

And so it passed in the Affirmative.

Former findings 66 to 69 read.

And the Question being proposed – That Former findings 66 to 69 be agreed to

The Committee divided.

Ayes	Noes

Ms *Dow* Mr *Behrakis*
Ms *Johnston* Mr *Wood*
Dr *Woodruff*

And so it passed in the Affirmative.

Former finding 70 agreed to as amended.

Measures:

Finding 78 Former finding 62 and 79 agreed to.

Finding 80 agreed to as amended.

Finding 81 agreed to as amended.

Finding 82 agreed to as amended.

Finding 83 agreed to,

Chapter 7

Finding 84 agreed to

Finding 85 agreed to as amended.

New finding x inserted in xx

Finding 86 agreed to as amended.

Finding 89 deleted.

Finding agreed to.

Findings x and x deleted.

Finding 90 agreed to.

Finding 91 deleted.

Finding 92 agreed to.

Finding 96 agreed to.

Resolved, that the findings, as agreed to, be the findings of this Committee (Dr *Woodruff*).

Other matters

Resolved, that the Committee Chair move a motion in the House extending the reporting date of the Committee until 21 November 2024.

Resolved, that the Committee reserve the following dates for the completion of the Committee Report:

31 October 2024 – 12 p.m. to 3 p.m.

11 November 2024 – 1 p.m. to 3 p.m.

At 4:35 p.m. the Committee adjourned until Thursday, 31 October 2024.

Confirmed,

THURSDAY, 31 OCTOBER 2024

The Committee met in Committee Room 1, Parliament House, Hobart and via Webex at 12.06. p.m.

Members Present:

In person:
Dr *Woodruff* (Chair)

Via Webex:
Ms *Johnston*
Ms *Dow*
Mr *Wood*

APOLOGIES

Mr *Behrakis* and Ms *Haddad* were apologies.

MINUTES

The minutes of the meetings held 3 October 2024, 9 October 2024 and 10 October 2024 were agreed to (Ms *Dow*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

Finding 101 agreed to.

Additions to Chapter 1 considered

Paragraph 1.4 – 1.5, agreed to as amended.

Former paragraph 1.6 removed.

Paragraphs 1.19 – 1.21 (former paragraphs 1.20 – 1.22) agreed to as amended.

Additions to Chapter 2 considered

Former paragraph 2.53 removed from Chapter 2 and moved to Chapter 3, new paragraph 3.65.

Paragraph 2.54 (former paragraph 2.55) agreed to as amended.

Additions to Chapter 7 considered

Paragraph 7.6 agreed to as amended.

Recommendation

Insert new recommendations 43 – 47, in Chapter 7, as agreed to.

Recommendations considered

Major recommendations

Major recommendations 1 – 3 agreed to.

Major recommendation 4 agreed to, as amended.

Major recommendations 5 – 6 agreed to.

Detailed recommendations

Causes

Recommendations 1 – 5 agreed to.

Recommendations 6 – 7 agreed to as amended.

Recommendations 8 – 12 agreed to. Noted that Recommendations 11 – 12 also appear in Chapter 7, this will be further considered.

Effects

Recommendation 13 agreed to as amended.

Recommendations 14 – 19 agreed to.

Former recommendation 20 removed.

Recommendation 25 (former recommendation 26) agreed to.

Recommendation 26 (former recommendation 27) agreed to as amended.

State Government's Response

Recommendations 27 – 28 (former recommendations 28 – 29) agreed to.

Short-, Medium- and Long-Term solutions

Recommendation 29(former recommendation 30) agreed to.

Recommendation 30 (former recommendation 31) agreed to as amended.

Recommendations 31 – 33 (former recommendations 32 – 34) agreed to.

Recommendation 34 (former recommendation 35) agreed to as amended.

Data collection

Recommendations 20 – 21 (former recommendations 21 – 22) agreed to as amended.

Recommendation 22 (former recommendation 23) agreed to.

Recommendations 23 – 24 (former recommendations 24 – 25) agreed to as amended.

Committee Chair to assess order and placement of recommendations and provide Committee Members with an update for assessment at the Committee's next meeting.

Other matters

No other matters.

At 1.24 p.m. the Committee adjourned until 1 p.m. Monday, 11 November 2024.

Confirmed,

MONDAY, 11 NOVEMBER 2024

The Committee met in Committee Room 3, Parliament House, Hobart and via Webex at 1.04. p.m.

Members Present:

In person:
Dr *Woodruff* (Chair)
Mr *Behrakis*

Via Webex:
Ms *Dow*
Ms *Haddad*
Mr *Wood*

APOLOGIES

Ms *Johnston* was an apology.

MINUTES

The minutes of the meetings held 31 October 2024 were agreed to (Mr *Wood*).

TABLING OF REPORT

Resolved, that upon tabling, a press release be circulated noting the report of the Committee (Ms *Haddad*).

Resolved, that upon tabling, submitters and witnesses be contacted regarding the report of the Committee, including being sent a link to the Committee's webpage to access the report (Mr *Behrakis*).

CONSIDERATION OF CHAIR'S DRAFT REPORT

The Committee considered the Chair's draft report.

Contents page

Remove 'Short-, Medium- and Long-Term Actions.'

Remove, from point 7, 'By the State Government.'

Contents page, agreed to as amended. Chapter titles to be updated accordingly.

Remove heading 'Short-, Medium- and Long-Term Actions' and change to 'Further Actions That Can Be Taken' in Findings. Heading agreed to as amended.

Recommendations

Detailed Recommendations

Agreed to removed former recommendations 11 and 12.

Recommendation 18 reconsidered and agreed to as amended.

Finding 95 reconsidered and agreed to as amended.

Finding 97 reconsidered and agreed to as amended.

Agreed Emergency Department to be capitalised throughout the report. (Dr *Woodruff*)

Finding 101 reconsidered and agreed to as amended.

Agreed to remove former recommendation 32.

Recommendation 35 (former recommendation 36) reconsidered and agreed to as amended.

Resolved, that the draft report, as amended, be the report of the Committee (Ms *Dow*).

Other matters

None.

At 1.32 p.m. the Committee adjourned *sine die*.

Confirmed,

Appendix C: Correspondence

a) Letter dated 10 November 2023 from Secretary of the Department of Health, Kathrine Morgan-Wicks.

b) Letter dated 1 December 2023 from Secretary of the Department of Health, Kathrine Morgan-Wicks.

c) Letter dated 10 January 2024 from Ambulance Tasmania Chief Executive Jordan Emery.

d) Letter dated 22 July 2024 from Hon Guy Barnett, Minister for Health, Mental Health and Wellbeing in response to Questions on Notice.

e) Letter dated 22 July 2024 from Ambulance Tasmania Chief Executive Jordan Emery.

f) Additional information from Australian Nursing and Midwifery Federation (Tasmanian Branch) dated 22 July 2024 regarding the new Transfer of Care Protocol.

g) Additional information from Australasian College for Emergency Medicine dated July 2024 regarding the new Transfer of Care Protocol.

h) Letter received 26 July 2024 from Hon Guy Barnett, Minister for Health Mental Health and Wellbeing regarding the new Transfer of Care Protocol.

i) Additional information from of Australasian Medical Association dated 29 July 2024 regarding the new Transfer of Care Protocol.

Department of Health

GPO Box 125, HOBART TAS 7001, Australia
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Tasmanian Government

[redacted]

Ms Fiona Murphy
Secretary
Select Committee on Transfer of Care Delays (Ambulance Ramping)
transferofcare@parliament.tas.gov.au

Dear Ms Murphy

Subject: Provision of data requested by Select Committee

I refer to your letter dated 6 October 2023, requesting a range of data to assist the House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping) to understand transfer of care delays in Tasmania.

Please find attached responses to a majority of the questions asked.

With regard to question 8, 9, 10 and 13, these relate to areas of complexity where significant review is required. This work is ongoing and I anticipate a response to these questions will be provided to you by 30 November 2023.

Yours sincerely

[redacted]

Kathrine Morgan-Wicks
Secretary

10 November 2023

Enc:

[redacted]

Question 1

The annual percentage of patients subject to 15 minute and 30 minute 'offload delay' results by hospital and in total (state-wide) - from 2015-16 to 2022-23 (inclusive).

Table 1a: Percentage of patients arriving by ambulance - where transfer of care was more than 15 minutes (%)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	9.9	9.9	5.9	6.3	9.0
2016-17	15.6	7.0	10.1	9.5	11.8
2017-18	29.6	21.2	7.0	8.2	21.9
2018-19	33.7	24.9	4.6	5.2	24.3
2019-20	31.2	30.3	9.6	7.3	25.8
2020-21	33.8	38.6	22.5	14.9	32.0
2021-22	42.6	40.9	21.5	14.2	36.3
2022-23	48.0	44.6	21.3	13.2	39.8

Table 1b: Percentage of patients arriving by ambulance - where transfer of care was more than 30 minutes (%)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	6.2	6.8	3.1	3.6	5.7
2016-17	10.7	4.7	5.5	5.0	7.7
2017-18	23.5	15.8	3.7	4.6	16.6
2018-19	27.9	18.8	1.5	2.6	19.1
2019-20	24.4	24.3	4.9	3.8	19.8
2020-21	25.7	31.9	14.3	10.2	24.5
2021-22	34.3	34.9	13.2	8.9	28.9
2022-23	40.4	37.8	13.4	8.2	32.6

Notes:

1. *Table 1a presents a measure of the percentage of patients experiencing transfer of care delay. The first 15 minutes from arrival at an emergency department is treated as routine transfer of care and any period of time exceeding those 15 minutes as delay. For example, in 2022-23 for all hospitals 39.8% of patients arriving by ambulance experienced transfer of care delay, which is equivalent to saying that 60.2% were transferred within 15 minutes.*

Question 2

The 25th percentile, median, 75th percentile and 90th percentile wait times for patients subject to ramping, by hospital, from 2015-16 to 2022-23 inclusive.

Table 2a: Patients subject to transfer of care delay - 25th percentile time from arrival at the emergency department until transfer of care (minutes)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	25	27	22	23	25
2016-17	27	26	23	22	26
2017-18	34	30	22	23	31
2018-19	40	31	19	23	34
2019-20	34	35	21	22	32
2020-21	31	39	24	27	32
2021-22	37	43	24	25	35
2022-23	43	42	24	24	38

Table 2b: Patients subject to transfer of care delay - 75th percentile time from arrival at the emergency department until transfer of care (minutes)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	62	68	50	55	62
2016-17	67	66	54	50	64
2017-18	110	95	51	46	101
2018-19	141	93	36	45	123
2019-20	122	113	49	48	113
2020-21	112	144	62	68	113
2021-22	143	159	60	59	136
2022-23	188	150	63	59	161

Table 2c: Patients subject to transfer of care delay - 90th percentile time from arrival at the emergency department until transfer of care (minutes)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	95	108	76	78	96
2016-17	100	105	83	95	98
2017-18	171	154	86	69	162
2018-19	217	147	56	73	196
2019-20	189	191	77	78	184
2020-21	175	239	97	99	188
2021-22	225	258	92	86	224
2022-23	302	250	97	92	271

Note: The figures in Table 2c are likely to moderately overestimate the time from arrival until transfer of care (see general caveat for transfer of care data).

Question 3

The percentile at which patients are ramped for a period greater than five hours, six hours, and seven hours for each major hospital - from 2015-16 to 2022-23 (inclusive). e.g. *Patients at the LGH waiting for longer than five hours are in the 93rd percentile*

Table 3a: Patients subject to transfer of care delay - percentile at which time from arrival at the emergency department until transfer of care is within 5 hours

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	100	100	100	100	100
2016-17	100	99	100	96	99
2017-18	99	99	100	100	99
2018-19	97	99	100	99	98
2019-20	98	97	99	100	98
2020-21	98	94	100	100	97
2021-22	96	93	100	100	96
2022-23	90	94	100	100	92

Table 3b: Patients subject to transfer of care delay - percentile at which time from arrival at the emergency department until transfer of care is within 6 hours

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	100	100	100	100	100
2016-17	100	100	100	97	100
2017-18	100	99	100	100	100
2018-19	98	99	100	100	99
2019-20	99	98	99	100	99
2020-21	99	96	100	100	98
2021-22	98	96	100	100	98
2022-23	94	96	100	100	95

Table 3c: Patients subject to transfer of care delay - percentile at which time from arrival at the emergency department until transfer of care is within 7 hours

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	100	100	100	100	100
2016-17	100	100	100	98	100
2017-18	100	100	100	100	100
2018-19	99	100	100	100	99
2019-20	99	99	99	100	99
2020-21	100	98	100	100	99
2021-22	99	97	100	100	99
2022-23	96	98	100	100	97

Notes:

1. *The first 15 minutes from arrival at an emergency department is treated as routine transfer of care and any period of time exceeding those 15 minutes as delay. Accordingly, patients subject to transfer of care delay are those where the time until transfer of care is more than 15 minutes.*
2. *Where less than 100, the figures in Tables 3a, 3b, and 3c may underestimate the percentile of patients with a time until transfer of care that is less than the specified number of hours (see general caveat for transfer of care data).*

Question 4

The total number of patients subject to ramping annually, and the total number of hours these patients were ramped for, by hospital, from 2015-16 to 2022-23 (inclusive).

Table 4a: Patients subject to transfer of care delay

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	2 026	1 192	322	286	3 826
2016-17	3 224	855	620	419	5 118
2017-18	6 432	2 736	440	376	9 984
2018-19	7 640	3 382	318	232	11 572
2019-20	6 966	4 246	702	257	12 171
2020-21	8 496	5 815	2 051	494	16 856
2021-22	10 815	6 109	1 921	620	19 465
2022-23	12 193	6 552	1 727	635	21 107

Table 4b: Hours of transfer of care delay (hours)

Year	RHH	LGH	NWRH	MCH	All hospitals
2015-16	1 216	823	143	134	2 316
2016-17	2 064	591	316	318	3 289
2017-18	7 346	2 709	217	166	10 438
2018-19	11 267	3 233	88	105	14 694
2019-20	8 719	5 395	344	112	14 570
2020-21	9 664	9 360	1 204	313	20 542
2021-22	15 974	10 734	1 073	343	28 125
2022-23	24 301	10 975	1 048	350	36 674

Notes:

1. *The the first 15 minutes from arrival at an emergency department is counted as routine transfer of care and any period of time exceeding those 15 minutes as delay. Accordingly, patients subject to transfer of care delay are those where the time until transfer of care is more than 15 minutes.*
2. *As noted in the general caveats, data presented may vary from previous reporting due to review and improvements in calculation methods as part of end of financial year reporting. This includes a correction to LGH data where two locations where previously incorrectly included in transfer of care delay data, which had a significant impact on hours ramped.*

Question 5

The annual average time taken between paramedic crews arriving at hospital and being available for another callout, by hospital, from 2018-19 to 2022-23 (inclusive)

Table 5: Average time between paramedics arriving at hospital and being available for another callout (minutes)

Year	RHH	LGH	NWRH	MCH	All hospitals
2019-20	56.2	46.4	37.7	35.6	48.9
2020-21	57.3	54.0	47.1	46.2	53.9
2021-22	66.2	61.1	46.0	45.4	59.8
2022-23	61.8	60.1	41.9	41.1	56.5

Question 6

Regarding Emergency Services Computer Aided Dispatch (ESCAD) triage categories P0 and P1 patient transport only - the annual average time taken between paramedic crews arriving at hospital with such patients and being available for another callout, by hospital - from 2018-19 to 2022-23 (inclusive)

Table 6: Average time between paramedics arriving at hospital with a priority 0 or priority 1 patient, and being available for another callout (minutes)

Year	RHH	LGH	NWRH	MCH	All hospitals
2019-20	57.4	47.9	40.5	36.8	50.8
2020-21	58.0	55.8	48.7	47.4	55.3
2021-22	66.7	62.1	47.5	46.6	61.1
2022-23	62.9	61.8	43.4	41.3	58.2

Question 7

Annual average 'activation time' for ESCAD P0 and P1 graded ambulance calls, by region (south, north, north-west) - from 2018/19 to 2022/23 (inclusive).

Table 7: Average priority 0 and priority 1 patient activation times, by region

Year	South	North	North West	All regions
2019-20	4.3	4.4	3.8	4.2
2020-21	4.6	3.9	3.5	4.2
2021-22	4.4	3.1	2.7	3.7
2022-23	4.7	3.7	2.8	4.0

Question 11

A list of all reviews, studies, investigations, surveys, and analysis conducted by the government and/or government consultants into ramping, its causes, or its effects at a systemic level - including the date conducted and a brief description of the work and its findings.

A scan undertaken in the time available has identified the following relevant systemic-level reviews.

Year	Review	Description	Findings
2012 (released 2017)	Monaghan Review	Review of Royal Hobart Hospital Emergency Department patient flow process, including interface with greater hospital and ramping practices.	• Lack of engagement in emergency access reform throughout inpatient areas • Divide between the ED and the inpatient wards • 51 recommendations.
2014	The Commission on Delivery of Health Services in Tasmania	A report to the Australian Government Tasmanian Government Health Ministers on improving the sustainability of the Tasmanian health system.	• Hospital overcrowding, resulting in reduced patient flow, access block and overcrowded emergency departments, is a key issue facing the Tasmanian Healthcare system. • A lack of available hospital beds due to admission and discharge processes may be contributing to access issues.
2014	*One State, One Health System, Better Outcomes* reform program	The Tasmanian Government's *One State, One Health System, Better Outcomes* reform program focussed on the four major hospitals and defining their roles within the health system. Documents and consultation papers associated with the reforms included a Green Paper, Green Paper supplements, a Green Paper Issues Paper and a White Paper.	• Most of the causes of access block and ED overcrowding are outside the control of the ED. These include such factors as the access to diagnostics (imaging and pathology), delays in admission processes, lack of available appropriate inpatient beds and suboptimal inpatient discharge practice. • System wide process changes are required in order to achieve significant improvement in ED performance.

Year	Review	Description	Findings
2016	Staib, Sullivan and Timms Review	Review of access to emergency care at the Royal Hobart Hospital and Launceston General Hospital. The Review was initiated to inform the Tasmanian Government's *Patients First* initiative (described below).	• RHH and LGH have significant access block. • Difficult ED–inpatient interface and delayed discharged were limiting access to inpatient beds • Lack of clearly defined accountabilities for patient flow • Cultural and process barriers impeding improvements • 16 recommendations.
2016	*Patients First*	A Tasmanian Government Initiative to manage demand in Emergency Departments and improve whole-of-hospital patient flow at the Royal Hobart and Launceston General Hospitals.	• 19 actions, including developing and implementing: ○ a list of unacceptable "red flag" events in EDs ○ transparent, published principles for ED care ○ Clinical Initiative Nurses ○ Psychiatric Emergency Nurses at the RHH ○ Enhanced role of Paramedics
2017	Review of Ambulance Tasmania	A review of Ambulance Tasmania's clinical and operational services.	• Irrespective of the service model employed by Ambulance Tasmania, there will be periods in which excess demand on either EDs or the ambulance service which will impact upon the smooth flow of patients into and out of the hospital system. • There should be shared clinical governance of the patient's journey into emergency departments by both Ambulance Tasmania and emergency departments.
2019	Report of the Auditor-General	Analysis of the performance of Tasmania's four major hospitals in the delivery of the emergency department services.	• The incidence and duration of transfer of care delays across Tasmania's four major hospitals increased significantly between 2012-13 and 2017-18. • The delays reflect the combined impact of the growing number and complexity of ED presentations, ongoing access block to inpatient beds and limited bed capacity, particularly at the RHH. • Delays are also due to long-standing practices and behaviours within hospitals contributing to dysfunctional silos, poor coordination between inpatient areas and EDs, and the lack of a whole-of-hospital approach to improving patient flow.

Year	Review	Description	Findings
2019	Newnham and Hillis – Towards Outstanding Care at the Royal Hobart Hospital	An external review of patient access at the Royal Hobart Hospital.	• The RHH suffers from extreme access block. This leads to high rates of ambulance ramping. • There are many contributors to access block. First and foremost, the RHH carries an undue burden on health care for the whole of Hobart, with an excessive demand on the ED. • Leadership and governance changes have resulted in a loss of vision and the development of a "tribal" culture. This has led to an absence of a shared sense of risk across the organisation and impairs attempts to improve access and flow.
2019	Royal Hobart Hospital – Access Solutions	A compendium of occasional papers providing an overview of the issues impeding patient flow and access in the health system, to inform the Access Solutions Meeting on 19 June 2019 called by the Minister for Health and the Australasian College for Emergency Medicine.	• Provided a summary of past reviews, noting common findings included: ○ access block and overcrowding are system issues, not merely ED problems, and causes and solutions largely reside outside the ED, requiring a system-wide and whole-of-hospital approach. ○ The delay in accessing inpatient beds due to a 'difficult ED-inpatient interface' and delayed discharges that are reducing access to inpatient beds and is commonly identified as the main impediment to timely care. ○ Common barriers to moving patients out of the ED include poor access to inpatient beds due to inflexible systems or inadequate planning, inadequate specific bed numbers to cater for special needs, overreliance on intensive care/ high dependency beds, or delays in discharging patients to post-acute facilities and the community.

Question 12

Broken down by year and by hospital, the number of patients who have died while ramped - from 2018-19 to 2022-23 (inclusive).

The Department of Health records data, including date and time of death, for patients that die in hospital, including the Emergency Department.

Separately, the movement of patients between locations is administered through the TrakED emergency department information system.

A review of these two datasets over the period 2018-19 to 2022-23 has not identified any instances where the time of a patient's death is recorded as prior to transfer of care occurring.

This is consistent with how emergency departments operate. In situations where a patient significantly deteriorates (such as going into cardiac arrest) in the offload delay area, they are generally transferred to a resuscitation area or other part of the ED. If that patient is subsequently pronounced deceased by medical staff, that will occur, and be recorded, in that location.

Question 14

The following data for each month, starting with August 2019 and finishing in August 2023:

a) Average time spent at hospital by paramedics (by hospital)
b) Percentage of patients subject to ramping (by hospital)
c) Median and 90th percentile ambulance response times (by region).

Table 14a: Average time between paramedics arriving at hospital and being available for another callout (minutes)

Month	RHH	LGH	NWRH	MCH	All hospitals
Aug-19	58.7	49.0	36.3	34.0	50.2
Sep-19	56.4	49.0	35.7	37.0	49.3
Oct-19	55.6	52.3	38.1	37.3	50.1
Nov-19	59.9	43.9	35.9	36.8	49.5
Dec-19	55.4	46.4	35.8	35.5	48.1
Jan-20	57.8	42.6	36.8	36.1	48.3
Feb-20	58.8	41.9	37.8	35.1	48.5
Mar-20	53.3	43.6	36.4	35.6	46.0
Apr-20	46.3	49.2	40.1	33.1	46.8
May-20	49.3	47.8	43.9	68.3	48.0
Jun-20	53.8	44.2	41.4	35.6	48.2
Jul-20	53.7	52.1	40.4	37.5	50.2
Aug-20	54.6	50.6	44.4	39.9	51.1
Sep-20	56.9	51.6	44.4	38.7	52.4
Oct-20	49.9	52.5	43.5	36.5	49.2
Nov-20	56.7	51.2	45.2	44.0	52.6
Dec-20	58.2	49.3	46.7	44.1	52.9
Jan-21	56.5	54.1	45.9	43.4	53.2
Feb-21	58.1	58.1	50.2	46.8	56.0
Mar-21	63.4	59.7	51.0	51.2	59.2
Apr-21	57.4	51.8	54.1	48.1	54.5
May-21	61.9	56.7	50.2	46.9	57.2
Jun-21	59.7	60.6	48.9	55.1	57.7
Jul-21	66.5	58.1	50.6	49.9	60.0
Aug-21	67.6	59.4	44.2	45.8	59.7
Sep-21	57.5	60.6	47.2	43.9	55.5
Oct-21	59.8	61.8	45.0	46.5	56.8
Nov-21	60.3	52.4	43.5	43.8	54.1
Dec-21	63.6	54.3	46.7	45.0	56.8
Jan-22	64.9	55.1	46.5	44.3	57.4
Feb-22	68.6	64.1	46.0	41.9	61.4
Mar-22	68.7	68.4	46.3	42.4	62.8

Month	RHH	LGH	NWRH	MCH	All hospitals
Apr-22	72.8	59.7	44.6	45.1	62.3
May-22	68.5	69.7	44.7	48.1	63.4
Jun-22	76.2	70.0	46.2	47.2	67.2
Jul-22	77.2	66.4	50.7	44.3	67.0
Aug-22	59.7	67.9	47.7	44.8	58.7
Sep-22	61.2	64.8	42.6	46.9	57.9
Oct-22	62.6	63.3	39.9	41.7	57.6
Nov-22	70.3	54.5	41.8	41.2	59.1
Dec-22	70.5	62.7	41.9	38.8	61.0
Jan-23	57.4	55.6	38.7	38.8	52.5
Feb-23	56.3	51.2	40.4	39.5	50.9
Mar-23	57.4	58.4	42.3	41.9	53.9
Apr-23	54.2	52.6	38.8	38.2	50.1
May-23	56.5	59.2	40.1	38.2	53.0
Jun-23	59.6	66.2	36.8	39.4	55.9
Jul-23	64.6	57.3	39.7	39.5	56.2
Aug-23	63.7	54.2	41.1	39.1	55.4

Table 14b: Percentage of patients arriving by ambulance - where transfer of care was more than 15 minutes (%)

Month	RHH	LGH	NWRH	MCH	All hospitals
Aug-19	33.6	35.2	7.9	6.3	27.4
Sep-19	33.3	44.2	11.1	8.7	30.7
Oct-19	35.2	43.6	12.3	9.4	31.0
Nov-19	35.6	32.5	7.0	9.3	27.7
Dec-19	31.4	31.5	4.4	9.7	25.4
Jan-20	36.9	22.6	11.5	9.3	26.4
Feb-20	38.7	16.1	10.7	4.7	24.7
Mar-20	27.5	24.0	8.4	5.2	21.3
Apr-20	7.7	24.7	5.7	0.0	14.4
May-20	19.6	31.7	11.4	0.0	22.6
Jun-20	29.2	23.8	14.7	2.1	24.2
Jul-20	27.6	40.4	10.9	2.5	27.3
Aug-20	28.0	37.9	17.6	2.6	28.1
Sep-20	35.5	38.3	26.4	8.4	33.7
Oct-20	24.3	39.4	16.1	4.7	27.0
Nov-20	31.3	36.7	17.0	7.0	29.5
Dec-20	32.4	29.5	18.3	9.0	27.6
Jan-21	32.3	36.0	20.2	10.0	29.8
Feb-21	37.3	42.5	25.9	16.1	35.2
Mar-21	43.1	46.5	28.9	26.0	40.1
Apr-21	36.4	33.9	33.0	16.9	33.5
May-21	38.7	37.7	26.9	14.4	34.2

Month	RHH	LGH	NWRH	MCH	All hospitals
Jun-21	38.4	45.1	29.1	30.1	37.9
Jul-21	44.9	37.9	30.8	18.8	38.3
Aug-21	48.3	48.2	15.1	14.0	39.8
Sep-21	40.2	46.8	20.8	14.2	36.5
Oct-21	40.7	47.1	17.1	13.1	36.4
Nov-21	39.7	33.5	18.4	13.4	32.4
Dec-21	38.7	31.9	21.1	9.1	31.6
Jan-22	40.1	25.4	25.3	18.6	31.8
Feb-22	41.1	37.1	21.4	7.4	33.8
Mar-22	43.6	47.2	21.3	16.4	38.7
Apr-22	44.1	35.6	19.5	13.8	35.3
May-22	42.5	44.1	21.9	15.7	37.4
Jun-22	47.5	53.9	25.3	15.0	43.0
Jul-22	52.0	49.4	29.7	19.1	44.6
Aug-22	43.9	52.4	25.7	17.6	41.0
Sep-22	47.8	43.0	21.4	19.1	39.7
Oct-22	46.0	47.5	19.3	12.7	39.4
Nov-22	51.4	27.0	22.0	8.4	36.4
Dec-22	51.5	43.1	15.2	7.5	39.6
Jan-23	43.6	39.2	13.2	6.6	34.7
Feb-23	45.8	38.9	16.8	12.1	36.4
Mar-23	49.0	43.3	27.0	18.9	41.2
Apr-23	45.8	38.5	20.1	13.2	37.2
May-23	48.4	53.0	27.3	12.7	43.3
Jun-23	51.0	59.5	15.9	11.0	44.1
Jul-23	51.1	48.2	24.6	13.8	42.5
Aug-23	52.8	43.6	20.9	11.3	41.7

Note: Table 14b presents a measure of the percentage of patients experiencing transfer of care delay. The first 15 minutes from arrival at an emergency department is treated as routine transfer of care and any period of time exceeding those 15 minutes as delay.

Table 14c(1): Median ambulance response time by region, priority 0-1 (minutes)

Month	South	North	North West	All regions
Aug-19	14.3	13.9	12.7	13.9
Sep-19	13.9	14.0	11.8	13.5
Oct-19	13.9	14.9	12.7	13.8
Nov-19	13.8	13.9	12.6	13.6
Dec-19	14.5	14.7	11.7	14.0
Jan-20	14.1	14.4	12.1	13.8
Feb-20	13.8	14.1	11.9	13.5
Mar-20	14.0	15.2	12.6	13.8
Apr-20	13.7	15.2	13.3	13.9
May-20	14.4	13.6	12.8	13.8
Jun-20	14.4	13.7	11.9	13.6
Jul-20	13.8	13.6	12.1	13.2
Aug-20	13.7	13.7	13.3	13.7
Sep-20	14.9	13.6	12.4	13.8
Oct-20	14.1	13.7	13.0	13.7
Nov-20	15.4	13.6	13.3	14.5
Dec-20	14.9	13.7	12.9	14.2
Jan-21	15.9	14.1	12.3	14.5
Feb-21	15.8	14.3	13.2	14.8
Mar-21	16.4	14.4	12.2	15.0
Apr-21	15.7	13.3	12.3	14.0
May-21	14.9	13.4	12.0	13.7
Jun-21	14.9	13.6	11.4	13.7
Jul-21	16.1	13.4	11.7	14.4
Aug-21	16.5	13.8	11.1	14.5
Sep-21	15.2	13.4	11.3	13.9
Oct-21	15.5	13.4	11.5	13.9
Nov-21	15.5	13.1	11.0	13.7
Dec-21	15.4	13.6	11.0	13.9
Jan-22	16.4	14.2	12.1	14.8
Feb-22	15.8	13.7	12.0	14.2
Mar-22	16.9	14.2	11.9	14.8
Apr-22	16.5	14.2	11.6	14.6
May-22	15.7	13.8	11.8	14.4
Jun-22	16.7	13.9	12.1	14.8
Jul-22	16.9	14.2	11.4	15.0
Aug-22	15.5	13.6	11.6	14.0
Sep-22	14.7	14.0	12.0	14.0
Oct-22	15.4	14.2	11.5	14.2
Nov-22	16.2	14.0	11.1	14.6
Dec-22	18.8	14.6	11.8	15.9
Jan-23	16.6	14.0	11.9	14.6

Month	South	North	North West	All regions
Feb-23	16.4	14.5	11.3	14.6
Mar-23	15.7	14.6	11.5	14.4
Apr-23	15.1	14.3	11.9	14.2
May-23	14.6	14.1	11.5	13.8
Jun-23	16.0	14.9	10.8	14.5
Jul-23	16.2	14.4	11.0	14.6
Aug-23	16.2	14.5	11.5	14.6

Table 14c(2): 90th percentile ambulance response time by region, priority 0-1 (minutes)

Month	South	North	North West	All regions
Aug-19	32.0	36.3	28.7	32.7
Sep-19	32.5	31.5	27.8	31.0
Oct-19	32.6	36.0	29.8	33.3
Nov-19	31.8	35.7	28.9	32.1
Dec-19	33.8	34.5	28.8	33.0
Jan-20	35.4	34.8	31.0	34.6
Feb-20	34.4	34.4	28.3	32.8
Mar-20	31.6	38.1	30.9	33.6
Apr-20	29.3	33.5	30.7	30.4
May-20	33.5	31.8	30.6	32.4
Jun-20	35.3	35.1	28.5	34.1
Jul-20	33.3	32.3	26.0	31.4
Aug-20	32.2	32.3	32.5	32.4
Sep-20	34.2	30.7	27.7	31.8
Oct-20	32.9	32.9	32.5	32.9
Nov-20	34.6	34.5	33.2	34.0
Dec-20	33.5	34.9	31.1	33.3
Jan-21	34.9	35.9	28.3	34.6
Feb-21	35.3	38.0	29.5	35.1
Mar-21	37.1	36.3	29.6	35.5
Apr-21	36.3	31.3	31.9	34.4
May-21	35.0	31.8	25.3	31.7
Jun-21	35.6	32.3	26.6	32.5
Jul-21	35.6	33.2	25.5	33.2
Aug-21	35.7	32.1	26.3	32.8
Sep-21	33.4	32.2	26.6	31.8
Oct-21	35.0	34.7	28.2	34.0
Nov-21	36.6	32.0	24.8	33.0
Dec-21	36.0	31.7	28.6	33.2
Jan-22	36.8	32.9	28.3	34.0
Feb-22	38.7	35.6	27.9	35.1
Mar-22	41.3	33.0	29.9	36.7
Apr-22	37.3	32.1	24.4	34.5

Month	South	North	North West	All regions
May-22	36.0	29.7	27.6	33.3
Jun-22	40.6	34.6	27.6	36.0
Jul-22	39.1	36.4	26.2	36.6
Aug-22	35.4	33.0	26.7	33.4
Sep-22	33.8	33.6	26.4	32.8
Oct-22	36.4	31.9	26.7	33.7
Nov-22	39.1	31.6	26.7	35.3
Dec-22	47.8	33.9	27.9	40.7
Jan-23	41.7	34.5	25.9	36.7
Feb-23	37.4	33.7	25.3	34.3
Mar-23	36.2	33.4	28.2	33.8
Apr-23	35.7	32.3	27.8	33.4
May-23	32.4	33.2	25.3	31.4
Jun-23	38.3	35.4	23.2	34.8
Jul-23	38.3	35.8	25.4	35.8
Aug-23	36.4	33.9	26.4	34.1

Notes on Data

General Caveat for Transfer of Care Data

Current information systems do not specifically record the point of transfer of care between ambulance paramedics and emergency department staff. Instead, transfer of is derived from data using the location of the patient and whether that location is designated as under the care of ambulance paramedics. Patients may be moved between these locations, including to receive diagnostic and therapeutic interventions in another part of the hospital, before transfer of care from ambulance paramedics is completed.

To ensure that no delays in the transfer of care are overlooked, the Department measures the time from arrival (as recorded in the emergency department information system) to the end of the final location under the care of ambulance paramedics. However, patients are sometimes incorrectly recorded as being in a location under the care of ambulance paramedics, and the emergency department information system does not allow this to be reliably corrected for performance reporting.

There is no operational impact from this data limitation. However, it does mean that the time before transfer of care will be overestimated in some instances and estimates focussed on patients with the longest time until transfer of care, including those above the 95th percentile time until transfer of care, will be less unreliable.

Data presented in this response may vary from previous reporting due to review and improvements in calculation methods as part of end of financial year reporting.

Timeframe of Ambulance Tasmania data

Ambulance Tasmania upgraded its dispatch system in 2019. Consequently, data prior to the 2019-20 financial year is not comparable to data within the new system. Therefore, data relating to ambulance and paramedic performance is provided from 2019-20 rather than 2018-19. Data from 2018-19 can be provided upon request if required by the Select Committee.

Acronyms

RHH:	Royal Hobart Hospital
LGH:	Launceston General Hospital
NWRH:	North West Regional Hospital
MCH:	Mersey Community Hospital

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Ms Fiona Murphy
Secretary
Select Committee on Transfer of Care Delays (Ambulance Ramping)
transferofcare@parliament.tas.gov.au

Dear Ms Murphy

Subject: Provision of data requested by Select Committee – Final Response

I refer to your letter dated 6 October 2023, requesting a range of data to assist the House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping) to understand transfer of care delays in Tasmania, and my initial response to that request, dated 10 November 2023.

As noted in my initial response, additional time was required to prepare responses to questions 8, 9, 10 and 13 of the Committee's request due to the complexity of the areas covered by those questions.

Responses to those questions have now been prepared and are attached.

Yours sincerely

[redacted]

Dale Webster on behalf of

Kathrine Morgan-Wicks
Secretary

1 December 2023

Question 8

The number of Safety Reporting and Learning System (SRLS) reports made annually relating to medical risks and/or incidents affecting ramped patients from 2018-19 to 2022-23 (inclusive).

Table 1 provides a count of the number of SRLS events recorded from 2018-19 to 2022-23 that may relate to medical risk or incident affecting patients subject to Transfer of Care delay.

Table1: SRLS events potentially related to patients subject to Transfer of Care delay 2018-19 to 2022-23

Severity Assessment Code (SAC)	2018-19	2019-20	2020-21	2021-22	2022-23	Total
SAC 1	0	0	2	1	2	5
SAC 2	9	6	4	4	7	30
SAC 3	31	14	27	39	22	133
SAC 4	44	51	43	63	50	251
Rating not assigned	0	1	0	0	0	1
Total	**84**	**72**	**76**	**107**	**81**	**420**
Ambulance Arrivals at ED	47 654	47 102	52 593	53 612	53 002	253 963
All reported events as proportion of ambulance arrivals at ED (%)	0.176	0.153	0.145	0.200	0.153	0.165
SAC 1 and SAC 2 events as proportion of ambulance arrivals at ED (%)	0.019	0.013	0.011	0.009	0.017	0.014

This is a count of all patient/client safety events that were reported at an Emergency Department or Ambulance Tasmania, where the words 'transfer of care', 'offload delay', 'ramped', 'ramping' or 'ramp' appeared in the description or exact location field. Please note that as a result, this may include some incidents not directly related to ambulance transfer.

The table includes the Severity Assessment Code (SAC) for these events – with SAC 1 and SAC 2 incidents considered serious safety events.

Over the period covered by the data, there were 420 events recorded in total, which is equivalent to 0.165 per cent of the 253 963 ambulance arrivals to ED over that time. Of those, 91.7 per cent of reported incidents were in the lower severity categories. Serious safety events were equivalent to 0.014 per cent of all ambulance arrivals over that time.

Question 9

The number of investigations undertaken annually into SRLS reports related to medical risks and/or incidents affecting ramped patients – from 2018-19 to 2022-23 (inclusive).

All incidents reported on SRLS require review or investigation, with the severity of the incident determining the process for the investigation. Therefore, the number of SRLS incidents investigated annually is equivalent to the number of SRLS reports made, as provided in response to Question 8.

The SRLS generates a Severity Assessment Code (SAC) from one to four based on each incident's level of harm, level of care and treatment required, with SAC 1 being the most severe and SAC 4 the least severe.

The Department of Health's *Policy on Safety Event Management* specifies the following requirements for the investigation of incidents reported on SRLS:

- All SAC1 events are investigated using a Root Cause Analysis methodology. This is a standardised system-based approach used to investigate serious safety events for analysis and identification of system-based causes.
- All serious safety events (SAC 1 and/or SAC 2 ratings) are formally investigated, analysed and managed, with actions taken as appropriate, recommendations made and the event closed within 70 days from the date the event was reported into SRLS.
- All SAC3 and SAC4 events are investigated, analysed and managed with actions taken as appropriate and closed within 36 calendar days of the event being reported into SRLS. This often occurs at a local operational level.

Question 10

All SRLS reports related to medical risks and/or incidents affecting ramped patients – from 1 January 2021 to 30 June 2023 (personal identifying information omitted).

Table 2 provides the severity assessment classification, category, process and problem reported for all relevant safety events, as defined in the response to Question 8. These data are for the period 1 January 2021 to 30 June 2023. Over this time, there were 49,959 instances of transfer of care delay (transfer exceeding fifteen minutes) statewide.

This is information as recorded in the SRLS, extracted at summary level to ensure no personally identifying information is disclosed.

Table 2: Summary of SRLS reports, 1 January 2021 to 30 June 2023.

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
Behaviour					4	19	23
	N/A	Aggressive/Inappropriate Behaviour			2	10	12
		Missing Patient/Client				3	3
		Other				6	6
		Self Harming Behaviour			2		2
Care Management Process			4	5	40	63	112
	Admission	Incomplete/Inadequate			3		3
	Consent	Incomplete/Inadequate				1	1
	Discharge	Wrong Process/Service				1	1
	Emergency Response	Incomplete/Inadequate		1	4	5	10
		Not Performed				1	1
		Other				1	1
		Wrong Process/Service		1			1
	Handover	Incomplete/Inadequate		1	6	4	11
		Not Performed			2	7	9
		Other				1	1
		Unavailable			1	6	7

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
	Other (Clinical Administration Process)	Incomplete/Inadequate			3	2	5
		Not Performed		1		2	3
		Other			1	6	7
	Referral/Consultation	Incomplete/Inadequate				1	1
		Not Performed				1	1
		Other				2	2
	Task Allocation	Incomplete/Inadequate				3	3
		Not Performed				1	1
		Other	1			1	2
	Transfer of Care	Incomplete/Inadequate	2	1	12	5	20
		Not Performed			1	1	2
		Other	1		1	6	8
		Unavailable			3	4	7
		Wrong Process/Service			2	1	3
	Waiting List	Incomplete/Inadequate			1		1
Clinical Process/ Procedure			1	6	23	36	66
	Diagnosis/Assessment	Incomplete/Inadequate			2	3	5
		Not Performed			1		1
		Unavailable			1	1	2
	General Care/Management	Incomplete/Inadequate	1	2	5	8	16
		Not Performed			1	3	4
		Other			1	2	3
		Wrong Process/Treatment/Procedure				2	2
	Other (Clinical Process process)	Incomplete/Inadequate		1	1	2	4
		Not Performed			2	1	3
		Other				3	3
		Unavailable			1		1

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
	Procedure/Treatment/Intervention	Incomplete/Inadequate			1	2	3
		Not Performed			1	2	3
		Other				2	2
		Unavailable			1		1
		Wrong Process/Treatment/Procedure		1	1	1	3
	Recognition and Response to Deterioration	Incomplete/Inadequate		1	4	2	7
		Other		1			1
	Screening/Prevention/Routine Checkup	Incomplete/Inadequate				2	2
Documentation					1	4	5
	N/A	Document for Wrong Patient or Wrong Document				2	2
		Document Missing or Unavailable			1	2	3
Equipment/Medical Device					2	5	7
	N/A	Dislodgement/Misconnection/Removal				1	1
		Lack of Availability			2	2	4
		Other				2	2
Falls					3	3	6
	N/A	Collapse			1	1	2
		Loss of Balance			1		1
		Other (falls problem 2)			1	1	2
		Slip				1	1
Healthcare associated infection						1	1
	N/A	Infection Control Processes/Procedures				1	1

Category	Process	Problem/Issue	SAC1	SAC2	SAC3	SAC4	Total
Medication IV Fluids					3	7	10
	Administration to patient/client	Extra/duplicate dose				2	2
		Failure of administration technique				1	1
		Incomplete/ missing or error in documentation				1	1
		Omitted dose			2	1	3
		Wrong time (too early/too late)			1	1	2
	Ordering, storage and disposal	Misplaced medication				1	1
Skin Tissue					2		2
	N/A	Blister			1		1
		Pressure Injury			1		1
Total			**5**	**11**	**78**	**138**	**232**

Question 13

Broken down by year and by hospital, the number of patients who have died within 24 hours of Emergency Department/hospital admission after having been subjected to extended (greater than 30 minutes) ramping from 2018-19 to 2022-23.

The Department of Health records data, including date and time of death, for patients that die in hospital, including the Emergency Department (ED).

A review of these two datasets over the period 2018-19 to 2022-23 identified 136 deaths that occurred within 24 hours of care being transferred to the ED, following delayed transfer of care (exceeding 30 minutes). These cases are outlined in table 3 below.

As ambulance arrivals usually reflect the most acutely unwell presentations, it is not unexpected that some patients will die while in hospital, with around half the deaths in Tasmania each year occurring in a major hospital. A causal link cannot be drawn between transfer of care delay and cause of death based on these administrative data.

The deaths in Table 3 are equivalent to 0.014 per cent of ambulance arrivals over the period.

Table 3: Deaths within 24 hours of delayed transfer of care

Hospital	2018-19	2019-20	2020-21	2021-22	2022-23
LGH	4	8	11	10	9
MCH	0	0	3	0	3
NWRH	2	0	4	6	6
RHH	10	10	12	12	26
	16	18	30	28	44

Note: An additional 24 deaths occurred on the day after transfer of care; however, these cases have a date recorded but not an accurate timestamp, so it cannot be ascertained if they occurred with 24 hours or later. This would primarily represent deaths that occur following discharge from hospital, where time of death is generally not available in hospital information systems.

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Ms Fiona Murphy
Secretary
Select Committee on Transfer of Care Delays (Ambulance Ramping)
transferofcare@parliament.tas.gov.au

Dear Ms Murphy

Subject: Corrections of statements made at the hearings of 12 and 14 December 2023

On 12 and 14 December a number of witnesses attended hearings of the Select Committee on Transfer of Care Delays to provide their testimony, additional information regarding their statements and to respond to questions from the Committee.

The purpose of this letter is to directly address that a number of those statements were factually inaccurate, and I write to you today in my capacity as Chief Executive of Ambulance Tasmania to address these inaccuracies and to correct the public record.

Issue 1: The claim by Mr Ryan Posselt that paramedics are advised to complete mandatory training while awaiting transfer of care.

In his initial written submission to the Select Committee, an Ambulance Tasmania paramedic, Mr Ryan Posselt claimed that it is an organisational expectation of Ambulance Tasmania that paramedics will complete mandatory online training while they are awaiting transfer of care.

On 12 November he repeated this claim in person to the Select Committee. This statement is inaccurate.

Ambulance Tasmania can confirm it *recommends* paramedics utilise their down time whilst on shift to complete mandatory training, should it be appropriate to do so and does not interfere with the undertaking of their rostered duties. Ambulance Tasmania places has not directed paramedics/volunteers to complete training while they are on a meal break or when providing patient care. This includes at any time when involved in transfer of care delays.

When paramedics are not actively involved on an incident it is encouraged, but not mandated, that they will utilise this time while on station to complete training packages.

Ambulance Tasmania acknowledges there have been instances where paramedics have not completed mandatory training by required due dates. In those exceptional circumstances special arrangements have been put in place.

For example, at the beginning of the next rostered shift, those paramedics required to complete or renew mandatory training are released from operational duties to allow them to complete it at work whilst being paid. Once that training is completed the individual then returns to operational duties.

Essential Skills Maintenance (ESM), referred to as the: "*two days training*" by Mr Posselt, is currently being rolled out for all operational staff across the state, as per the Award. This is being conducted in South, North, North West and the Communications Centre by a combination of Clinical Support Officers and trained ESM instructors within each area.

It is projected that all staff will have completed the initial mandatory ESM training prior to 19 February 2024.

As of 17 December 2023, a total of 185 staff (37%) statewide have been provided the required ESM training. At times, ESM training has been rescheduled to meet operational resourcing requirements due to short notice roster changes. This training is provided at a later date, with no impact to the paramedic's rostered work hours.

Issue 2: The claim by Mr Ryan Posselt that every hour there is a lights and sirens job the Communication Centre reads out that gets no response.

In his initial written submission to the Select Committee Ambulance Tasmania paramedic, Mr Ryan Posselt claimed that multiple times a day, dispatchers are forced to read a priority response pending with no available response.

On 12 November he repeated this claim in person to the Select Committee. Ambulance Tasmania believes the statement by Mr Posselt that: "every hour there is a P1/P0 case that gets no response" is incorrect.

Ambulance Tasmania has procedures that are followed, with collaboration between the Ambulance Tasmania Deployment Supervisor, Ambulance Tasmania Operations Supervisors and staff at the Emergency Departments to release crews that are at hospital when there are un-resourced P1/P0 cases in the community. The broadcasting of all P1/P0 cases by the Emergency Medical Dispatcher is standard practice.

Issue 3: The claim by Mr Ryan Posselt that it is normal practice for paramedics to work an additional 1-2 hours after completing a 12-hour shift.

In his submission to the Select Committee Mr Ryan Posselt stated that paramedics anecdotally report 1-2 hours overtime after completing a 12-hour shift and that this practice is a completely normal and expected part of the day.

This statement is not accurate.

The nature of emergency services work does result in some extension of shift overtime when incidents require immediate resourcing towards the end of a paramedic's rostered shift. Ambulance Tasmania is currently working with the Health & Community Services Union (HACSU) to draft an End of Shift Dispatch procedure which will restrict the dispatching of paramedics to only life-threatening cases in the final hour of their shift.

Issue 4: The claim made by Mr Lucas Digney, Industrial Manager of the Health & Community Services Union (HACSU), that on Saturday 9 December 2023 only forty percent of the night shift was covered.

On 14 November 2023 Mr Lucas Digney claimed, in response to questions from Dr Rosalie Woodruff MP, Chair of the Select Committee, that Ambulance Tasmania was only able to fill forty percent (40%) of the staff roster for the Northern region.

This statement is not correct.

Ambulance Tasmania agrees that staffing was impacted by COVID-19 absences and other sick leave absences within the service during the dates provided. However, regionally the North of the state had 77 percent (77%) coverage despite additional late-notice unplanned absences occurring.

Business continuity plans are applied in such circumstances and operational leaders work collaboratively with all regions statewide to resource anticipated community demands.

Should you have any queries, I would be happy to respond to those directly either by written submission or at the upcoming hearing for the Department of Health.

Sincerely

Jordan Emery

Chief Executive

10 January 2024

QUESTION ON NOTICE

Select Committee of Transfer of Care Delays (Ambulance Ramping)

ASKED BY: Rosalie Woodruff, Committee Chair

ANSWERED BY:

QUESTION:

(1) What reviews are currently underway in the health department and what are the timeframes for these reviews?

(2) How many full-time equivalent paramedics total FTE, including both permanent employees and those on fixed term contracts, are employed as of 7 February 2024, and 14 February 2024; and what are the projected number of paramedics planned to be employed by end July of this year?

(3) How many physical beds are there in regional health facilities that are not open and not staffed at the moment? (including the 30 at Scottsdale)

ANSWER:

1. Currently there are two reviews underway within the Department of Health:

   a. Lived Experience Representative Organisation Review with recommendations due in December 2024.
   This is a review of lived experience representative organisations within and beyond Tasmania to develop recommendations for the Government for what a lived experience representative organisation should look like in Tasmania (encompassing mental health, alcohol and other drugs and suicide prevention), including organisational and governance structure and sustainability.

   b. Alcohol and other drugs treatment services review: residential and withdrawal services. This aligns with work under the Tasmanian Drug Strategy, the Reform Agenda for the Alcohol and other Drugs Sector in Tasmania (and work commissioned to develop the Drug and Alcohol Service Planning Model (DASPM) for Tasmania with the University of New South Wales.

2. Please see the table below indicating the full-time, part-time and casual paramedic FTE. The data is gathered from payroll and is aligned closely with the requested dates.

   The paramedic FTE at 9 June 2024, is reflective of the projected FTE at the end of July 2024, with no further on-boarding of paramedics planned up until that time.

	04/02/2024	18/02/2024	09/06/2024
Permanent	465.95	476.47	475.49
Fixed Term	61.10	57.35	67.27
Casual	16.10	13.85	10.98
Grand Total	**543.15**	**547.68**	**553.74**

3. There are currently 19 beds closed across Tasmania due to lack of medical cover (12), renovations and maintenance (4) and redevelopment (3).

   James Scott Wing at Scottsdale had 28 beds that were residential aged care beds, these were transferred to the new build at May Shaw. However, these are not hospital beds.

APPROVED/NOT APPROVED

Hon Guy Barnett MP
Minister for Health, Mental Health and Wellbeing

Date: 22 July 2024

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Ms Fiona Murphy
Secretary
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Dear Ms Murphy

Subject: Select Committee on Transfer of Care Delays (Ambulance Ramping) Inquiry

Thank you for your correspondence dated 27 June 2024 which referred to the correspondence sent on 25 January 2024, seeking further information in relation to a number of issues relevant to the Inquiry. Please accept my sincere apologies for the delay, the requested data was being finalised when the Committee ceased at the prorogation of Parliament and dissolution of the House of Assembly on 14 February 2024 and Ambulance Tasmania were awaiting a further update.

I have addressed the request for information below:

1.The protocol(s) or document (s) setting out the guidelines for staff to complete mandatory online training

Ambulance Tasmania does not have a protocol or document that provides guidelines for staff regarding the completion of mandatory online training.

2. The number of P0 and P1 cases that were unable to be immediately assigned an ambulance in the 2022/23 year, broken down by region

Triple Zero calls to the Ambulance Tasmania Communications Centre are answered by Emergency Call-Takers (ECT) and triaged using the Medical Priority Dispatch System (MPDS). MPDS provides a series of questions that enables assessment of caller information and produces an appropriate determinant code aligned to Ambulance Tasmania's dispatch grid. The dispatch grid assigns the priority of the ambulance response based on the seriousness of the call. Priority 0 (P0) and Priority 1 (P1) cases are life-threatening cases that require an immediate dispatch of an emergency ambulance travelling under lights and sirens. These incidents are assigned to ambulance crews by an Emergency Medical Dispatcher within the Communications Centre.

The answering and triaging of Triple Zero calls is a structured process using MPDS. The complexity of the presentation, caller information and incident location influence the time taken to reach a determinant code

and therefore an incident priority. Furthermore, based on information from the caller, an initial Triple Zero call make be prioritised as a Priority 2 incident, and then during the course of additional questioning using MPDS, be upgraded to a Priority 1 incident.

The Ambulance Tasmania 'assigned' target – that is, the time taken to assign an ambulance to an incident for Priority 0 and Priority 1 cases is three (3) minutes from the answering of the Triple Zero call.

In 2022-23, the number of P0 and P1 cases that were not assigned an emergency ambulance response within three minutes is provided in the Table below.

Region	2022/23 Incidents with delayed activation	2022/23 percentage of Incidents with delayed activation	2022/23 Incidents with immediate activation (less or equal to 3 minutes)	2022/23 percentage of Incidents with immediate activation (less than or equal to 3 minutes)
North	2929	25.7	8 477	74.3 %
North West	1785	19.3	7 467	80.7 %
South	6711	29.7	15 913	70.3 %

3. The total number of paramedic shifts worked in the 2022/23 year

Ambulance Tasmania is unable to reliably report the total number of shifts worked for all of the 2022-23 year due to paper-based systems.

The establishment of a Daily desk capability in December 2022, centralised the recording of shifts worked and unfilled on a statewide basis. Data is provided for the period 31 December 2022 to 30 June 2023, as below:

Total shifts at establishment statewide 30 408

Total shifts worked statewide 26 879 (88.4 %)

Total shifts unfilled statewide 3 697 (12.6 %).

4. The number of paramedic shifts that have finished within 30 minutes of the rostered finish time in the 2022/23 year

Ambulance Tasmania does not have systems that enable this information to be captured at this time. The rollout of the Human Resources Information System (HRIS) may provide increased ability to capture this type of information.

5. The average length of overtime worked per shift by paramedics in 2022/23 ***(e.g. 5 shifts finish on time and 1 shift finishes 30 minutes late = average overtime per shift of 5 minutes)***

Ambulance Tasmania does not have systems that enable this information to be captured at this time. The rollout of the HRIS may provide increased ability to capture this type of information.

6. The number of paramedic shifts that would have resulted in a fully staffed roster in the Northern Region on the night shift of 9 December 2023

A fully staffed night shift roster for the Northern Region entails:

- Urban Stations - Three Launceston crews, which includes a CRU (single Intensive Care Paramedic response), two Mowbray crews and one an Operations Supervisor. A total of 11 paramedics
- Double Branch Stations – Single paramedic at Beaconsfield, Campbell Town, Deloraine, George Town and St Helens. A total of five paramedics
- Single Branch Stations – Single paramedic on-call overnight at Bridport, Longford, Miena, Scottsdale and Scamander. A total of five paramedics.

This totals 21 paramedics, or 16 on-shift and five on-call.

7. The number of paramedics that worked on the night shift of 9 December 2023

In the Northern Region prior to midnight a total of 16 paramedics were working, with eight on -shift and four on-call. After midnight there were 14 paramedics working, with 10 on-shift and four on-call. This entailed:

- Urban - Eight paramedics were on-shift before midnight and six were on-shift after midnight
- Double Branch Stations - Four paramedics were on-shift
- Single Branch Stations – Four paramedics were on-call.

Table – Summary of Northern Staffing – Night Shift 9 December 2023

Stations	**Full Staffing – Number of Paramedics**	**Actual Number of Paramedics – before midnight**	**Actual Number of Paramedics – after midnight**
Urban – including CRU and Operations Supervisor	11 (on-shift)	8 (on-shift)	6 (on-shift)
Double Branch	5 (on-shift)	4 (on-shift)	4 (on-shift)
Single Branch	5 (on-call)	4 (on-call)	4 (on-call)
Total	21	16	14
Total coverage - percentage	**100** %	**76** %	**67** %
Total on-shift coverage - percentage	**100** %	**70** %	**62.5** %

In correspondence to the Select Committee dated 10 January 2024, it was advised that the Northern Region night shift coverage on 9 December 2023, was 77 per cent (now corrected to 76 percent). I would like to acknowledge that this was the staffing coverage at the commencement of the night shift and that the response did not account for the change in staffing at midnight when two paramedics on overtime went off shift, with 62.5 per cent of staffing coverage for the remainder of the night shift.

8. The percentage of night shifts unfilled across the State from 1 July 2023 to 31 December 2023.

The percentage of night shifts unfilled across the State from 1 July 2023 to 31 December 2023, was15.36 per cent.

I trust the information provided will meet the requirements of the Select Committee.

Yours sincerely

Michelle Baxter
Acting Chief Executive

22 July 2024

ANMF
Tasmanian Branch

AUSTRALIAN NURSING & MIDWIFERY FEDERATION (TASMANIAN BRANCH)

SUBMISSION

Select Committee on Transfer of Care Delays

(Further ANMF Submissions)

22 July 2024

Australian Nursing & Midwifery Federation (Tasmanian Branch)

Organisation Overview

The Australian Nursing and Midwifery Federation (ANMF) is both the largest nursing and midwifery union and the largest professional body for the nursing and midwifery teams in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents around 8000 members and in total the ANMF across Australia represents over 250,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANMF is the industrial and professional representation of nurses, midwives and the broader nursing team, through the activities of a national office and branches in every state and territory. The role of the ANMF is to provide a high standard of leadership, industrial, educational and professional representation and service to members. This includes concentrating on topics such as education, policy and practice, industrial issues such as wages and professional matters and broader issues which affect health such as policy, funding and care delivery. ANMF also actively advocates for the community where decisions and policy is perceived to be detrimental to good, safe patient care.

Contact Information

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1. Introduction

This report provides further feedback to the Select Committee on Transfer of Care Delays following the recess of the Committee, its re-establishment, and regarding the recent introduction of the Transfer of Care procedure in public Emergency Departments (EDs) across the State. The Australian Nursing and Midwifery Federation (ANMF) (Tasmanian Branch) and its members have raised concerns about the implementation and operational experience of this procedure.

2. Background

The government introduced a non-mandatory Transfer of Care Procedure in public emergency departments following an application by the ANMF seeking a status quo order and further consultation. This was due to:

- Lack of information and consultation with nurses.
- No additional resources allocated to EDs in terms of staffing.
- No assessment of the suitability of existing EDs for rapid patient offloading.
- Limited improvement in patient flow and inpatient admission times to facilitate greater ED capacity.

Despite the non-mandatory nature of this procedure, operational experiences have varied, with significant pressure on EDs to manage additional patients without additional staff.

3. Key Issues and Impacts

1. **Operational Pressures in EDs**
    - **Increased Patient Load:** EDs have faced significant pressure to manage additional patients with no additional staffing. This has resulted in patients being cared for on trolleys in corridors and chairs, known as treatment points, with one nurse often caring for up to 14 patients.
    - **Resource Constraints:** Existing resources have been stretched thin, leading to compromised patient care and increased stress on nursing staff.
2. **Impact on the Royal Hobart Hospital (RHH) and Launceston General Hospital (LGH)**
    - **Capacity Constraints:** The RHH has limited capacity to line corridors with trolleys. Although a few additional staff were allocated, they were reassigned from existing positions, further depleting scarce nursing resources.

- **Similar Operational Experience:** Despite the limited impact on transfer of care delays, the RHH has faced similar pressures as other EDs, such as overcapacity scenarios regularly and insufficient staffing affecting both patient care and staff wellbeing.

3. **Failure to Improve Patient Care**

   - **Patient Care Quality:** The procedure has failed to improve patient care. Patients may enter the ED more quickly, but they do not always receive immediate care. At times, the care and monitoring provided in the ED are less adequate than what they would have received on an ambulance stretcher.

   - **Resource and Monitoring Deficiencies:** Many treatment points lack essential monitors, oxygen, and suction. Critically ill patients are sometimes cared for by a nurse responsible for multiple other patients, leading to compromised care.

4. **Ignored Recommendations for Improving Access and Flow**

   - **Lack of Holistic Approach:** The ANMF's calls for improving access and flow before implementing the procedure were ignored. This has led to deteriorating patient care quality and increased staff stress.

   - **Overcapacity Situations:** Instances like the one at the Launceston General Hospital (LGH) on June 7, where EDs were overrun with patients, ambulances and the LGH ED staff were desperately trying to find monitors from across the hospital to support the patients, while still 7 ambulances were ramped, highlight the ineffectiveness of the procedure without addressing broader systemic issues.

5. **Staff Impacts**

   The new procedure raises significant safety and patient care concerns and adversely affects staff workloads, stress levels, and burnout. Many staff members have reduced their hours to protect their mental health, experiencing significant distress before each shift due to fears of inadequate patient care. The procedure has shifted staffing and care delivery issues from the community and Ambulance Tasmania to emergency department staff. Despite addressing paramedic concerns, the government has ignored the operational, safety, and wellbeing impacts on nursing staff, claiming the procedure's success by moving patients from ambulances to corridors, away from public and ministerial scrutiny.

4. ANMF Support for Major Hospital ED Review Recommendations

The ANMF supports the recommendations of the Major Hospitals ED Review in principle, contingent on several factors:

- **Expansion of Community Paramedic Program:** The program should include Nurse Practitioners and nursing staff for expert clinical assessments and referrals to community nursing programs.

- **Holistic Nursing Care:** Nursing staff should provide comprehensive care in the community, supported by Nurse Practitioners, to reduce ED presentations.

- **Appropriate Staffing:** Any new services must be introduced with appropriate staffing without depleting existing clinical areas, addressing current staff deficits estimated to be close to 1,000 vacant positions.

5. Conclusion

To improve access and flow issues in EDs, a holistic approach is necessary. Simply banning ramping places undue pressure on already overcapacity EDs. Implementing the Major Hospitals recommendations, such as care@home programs and additional mental health support with proper resourcing and staffing, will improve patient flow across the healthcare system. The ANMF remains available to provide further evidence to the committee if required.

6. Recommendations

1. **Comprehensive Consultation:** Engage in thorough consultation with nursing staff and stakeholders before implementing procedures.

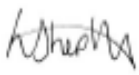
2. **Adequate Resourcing:** Ensure EDs are equipped with the necessary resources and staffing to manage increased patient loads.

3. **Holistic Approach to Flow Improvement:** Address systemic issues affecting patient flow from community care through to hospital discharge.

4. **Support for Community Programs:** Expand and adequately staff community programs to reduce ED presentations and improve patient care.

5. **Government Commitment to Address Existing Staffing Issues:** Review existing nursing and midwifery staffing shortfalls and address these immediately prior to implementing any further services or opening any additional beds.

The ANMF looks forward to continued collaboration with the government to enhance the quality of patient care and the working conditions of nursing staff and are available to provide further evidence to the committee if required.



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Submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) – July 2024

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to make a second submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) Inquiry (the Inquiry). ACEM commends the Select Committee for continuing the vitally important work of the previous Parliament.

ACEM has a long-standing interest in acute health system function, in particular hospital Emergency Department (ED) overcrowding, long ED wait times, and the management of patient flow throughout hospitals. Transfer of care (TOC) delays (ambulance ramping) and access block is a symptom of a health system in crisis. Access block is the single most serious issue facing EDs and the major contributor to ED overcrowding and TOC delays.

ACEM recognises the importance of ambulances being available to respond to emergencies in the community rather than being stuck outside a hospital. Our submission builds upon and reinforces key messages that were provided in the College's previous submission on 13 October 2023 (Appendix 1).

Year-upon-year, Tasmanian hospitals are experiencing worsening performance in TOC delays, waiting times, hospital lengths of stay and poorer patient outcomes. A whole-of-hospital and whole-of-system approach, coupled with increased investment in hospital and community-based services is desperately needed if the government is to successfully address the health system crisis.

1. The impacts of access block and transfer of care delays

ACEM notes that TOC delays are a very visible problem, often referred to in the media and part of public discourse. Importantly, ACEM also recognises this is not a new problem, with access block and TOC delays identified in numerous government consultations and audits in the past.

Access block is defined as the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than 8 hours because of a lack of inpatient bed capacity. This also includes patients who were planned for an admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED.

Access block and TOC delays caused by bottlenecks in other parts of the healthcare system have implications for patient safety. To put it simply, when EDs are access blocked due to hospital capacity, patients are at greater risk of dying and there is an increased risk of medical errors or of conditions being missed. The training and education of junior healthcare workers is also severely compromised, with the inter-professional conflict that emerges within the hospital environment increasing stress and decreasing job satisfaction, leading to higher rates of attrition and burnout.

2. Rapid offload policies

The interaction and handover of patients between the ambulance services and ED staff is critical to ensuring that patients receive the correct treatment in a timely fashion. ACEM members report that

their interactions with ambulance services are professional and that paramedics provide high-quality care within their scope of practice. However, TOC delays challenge the traditional 'respond, stabilise and transport' focus of ambulance services and raises an ethical dilemma for paramedics, who are effectively being asked to continue to provide ongoing emergency medical care for the patient beyond the scope and time frame of their expertise.

Whilst ACEM recognises the different imperatives of ambulance services and ED teams, the College does not support policies that allow for ambulance services to leave a patient in a transition area when there is no capacity within the ED to care for that patient. There have been occasions in other jurisdictions where ambulance services have trialled a 'rapid offload' model-of-care, whereby patients are left at the ED door without any transfer. In that model, ambulance staff cease to continue emergency medical care so that they can respond to other emergencies in the community.

Hospitals and EDs are already facing extremely high levels of demand and are staffed by a workforce that have endured unprecedented levels of pressure amidst the backdrop of a global pandemic, an exodus of senior healthcare workers, and chronic vacancy and recruitment issues. They also face the daily moral injury of wanting and being trained to help people, but being placed in a situation of being unable to do this to an appropriate level. This means rapid offload is a highly dangerous response, that will lead to greater harm and fewer patients receiving the care they need in a timely fashion.

Emergency physicians are deeply concerned that rapid offload policies becoming business as usual will soon lead to the return of 'corridor medicine' as part of their daily expectations, that patients in the waiting room will effectively be ignored in preference to patients in an ambulance and that non-clinician executives will attempt to direct clinical care.

3. Update on the Transfer of Care policy

ACEM wrote to the Minister for Health, the Hon. Guy Barnett MP on 31 May 2024 to express concerns about the mandated 60-minute TOC protocol. The College is extremely concerned by the government's framing and approach to the issue, as 'banning ramping' does not address the underlying issues that lead to ramping

Largely, ACEM's members report that the new mandate has had minimal effect on the operations of EDs and the broader hospital. TOC delays are reduced when there is flow throughout the hospital – however, whilst access block and overcrowded inpatient wards persist, there is very little that the mandate can do in these situations.

Our members have reported that the mandate has led to an increase in inter-professional conflict, where you have one party wanting to offload the patient, whilst the other party feel it is unsafe. The TOC mandate has increased the administrative load of ED staff, and ultimately, healthcare workers believe such arbitrary measures simply ignore the key issues that perpetuate the long-standing health system challenges in Tasmania.

4. Contact

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Hamish Bourne, Manager, Policy and Advocacy (Hamish.bourne@acem.org.au).

Yours sincerely,

Dr Juan Carlos Ascensio-Lane
Chair, Tasmanian Faculty
Australasian College for Emergency Medicine

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Minister for Health, Mental Health and Wellbeing
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Tasmanian Government

Ref: MIN24/1362

Rosalie Woodruff MP
Chair
Select Committee on Transfer of Care Delays (Ambulance Ramping)
Email: transferofcare@parliament.tas.gov.au

Dear Rosalie Woodruff MP

Thank you for your correspondence dated 28 June 2024, concerning the implementation of the *Transfer of Care Procedure* (the Procedure) and the *Independent Review of Tasmania's Major Hospital Emergency Departments* (7 May 2024).

The Procedure commenced on 22 April 2024, following extensive consultation across Ambulance Tasmania, the Tasmanian Health Service (THS), and relevant union bodies, including the Health and Community Services Union, Australian Nursing and Midwifery Federation (Tas) and the Australian Medical Association (Tas).

The Procedure requires transfer of patient care from Ambulance Tasmania staff to the care of THS Emergency Department (ED) staff within 60 minutes of arrival at the facility. The implementation period for the Procedure is 12 months from commencement, at which time a review will be undertaken.

Improved Transfer of Care

There has been a significant reduction in transfer of care delays, reflecting the new protocol as well as significant ongoing effort from hospital staff over the last 12 months to address this challenge.

I am advised that data for 2023-24 show there were 9,276 fewer hours of transfer of care delay in 2023-24. This is a reduction of 25.3 per cent compared to the prior year, with decreases at all four major public hospitals.

This is 9,276 hours of time returned to paramedic crews, ensuring greater availability for emergency responses.

Table 1 provides a breakdown by hospital.

Table 1: Hours of transfer of care delay

	2022-23	2023-24	*Change*
Royal Hobart Hospital	24,301	19,240	*-5,061*
Launceston General Hospital	10,975	7,134	*-3,841*
North West Regional Hospital	1,048	697	*-351*
Mersey Community Hospital	350	327	*-23*
Statewide	**36,674**	**27,398**	*-9,276*

Note:
1. For the purposes of recording hours of transfer of care delay, the first 15 minutes from arrival at triage within an emergency department is counted as routine transfer of care and any period of time exceeding those 15 minutes as delay. This is consistent with historical reporting allowing for comparability; however, it is recognised that in many instances clinically appropriate transfer of care will take longer than 15 minutes. Accordingly, this measure does not accurately measure transfer of care delays and should be considered alongside other performance information.
2. These data are measured using data from TrakED (the Emergency Department information system). This differs from the measurement of transfer of care within 60 minutes, which is calculated using Ambulance Tasmania informaiton systems.
3. The data for 2023/24 is preliminary, and will be reviewed as part of end of year processes.

The policy has had a positive impact on the percentage of incidents where transfer of care occurs within 60 minutes, with Statewide performance exceeding 80 per cent in both May and June 2024, with the preceding months experiencing less than 80 per cent.

Table 2 provides an overview of performance against the transfer of care targets.

Table 2: Ambulance Tasmania transfer of care within 60 minutes

Performance Measure	Unit of Measure	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024
Transfer of Care within 60 minutes (Statewide)	Percentage	71%	74%	76%	83%	80%
Transfer of Care within 60 minutes (RHH)	Percentage	66%	63%	66%	75%	74%
Transfer of Care within 60 minutes (LGH)	Percentage	66%	75%	77%	84%	76%
Transfer of Care within 60 minutes (MCH)	Percentage	87%	96%	98%	96%	96%
Transfer of Care within 60 minutes (NWRH)	Percentage	83%	92%	93%	95%	93%

It is acknowledged that significant effort has been undertaken at all the THS facilities to work towards achieving the targets.

Monitoring and Reporting

Within the health service, there has been high visibility of the transfer of care activity, with real-time dashboards operating in Emergency Departments and Ambulance Tasmania operations areas. The dashboards are also accessible to senior members of these organisations, including the Department of Health Executive and other relevant parties.

Transfer of care reports are published on a daily, weekly and monthly basis. Where transfer of care does not occur within the 60-minute period, these cases are investigated to determine why this has occurred, to better understand any barriers and implement solutions where possible.

In May 2024, the Department of Health launched a new daily Health System Dashboard with a range of new indicators covering emergency department and ambulance performance. This dashboard includes the percentage of patients transferred within one hour, broken down by major public hospital, and can be access online at: https://www.health.tas.gov.au/patients/health-system-dashboard

Independent Review of Tasmania's Major Hospital Emergency Department

Following the release of the *Independent Review of Tasmania's Major Hospital Emergency Departments* (7 May 2024), the Department of Health has placed considerable focus on the recommendations and is committed to working through this process methodically to ensure that our Health Services are positioned to provide the best possible care to those in most need of it.

It is pleasing to see the significant planning and policy work of the Department recognised in the report, alongside an acknowledgement of the hard-working, innovative, and dedicated health workforce who remain focused and dedicated to providing the highest levels of care to their patients and consumers.

Whilst the Department continues to make improvements across the system to address these long-term issues through the expansion of bed capacity across its major hospitals, additional efforts are required.

The final recommendations have been streamlined into key areas of focus and are underpinned by enhanced governance processes, by which all capacity and demand initiatives, improvements, results, and opportunities can be reviewed, agreed, enacted, measured, and celebrated as one health system across multiple services and sites.

Demand Management Strategies – Local & State Level

This grouping of recommendations includes enhanced governance structures, by which all capacity and demand initiatives, improvements, results, and opportunities can be reviewed, agreed, enacted, measured, and celebrated as one health system across multiple services and sites.

This is evidenced by work already completed to change the responsibilities and function of the Statewide Access & Patient Flow Program to focus on operational solutions and act as the project management team for local change management; alongside activities to establish a Statewide Integrated Operations Command Centre and frameworks to guide the roles and responsibilities in response to demand activity across the organisation by the end of the calendar year.

To support the local activities Chief Executives have outlined demand management project plans that provide detail on initiatives and activities that are being led across all arms of the health service to improve the flow of patients through the service, alongside both patient and staff experience.

Community & Home-Based Care

Building on the success of Care@home program, the Department will continue to develop this program of work to include sustainable service delivery models that promote integration across primary and secondary care and have a particular focus for people with chronic and complex conditions.

The recent appointment of an Executive Director of Nursing / Director of Services for the Department's home and community care program will further strengthen this program of work and ensure integration of programs of care that improve outcomes and conversely aim to reduce the rate of preventable hospitalisations.

Statewide Mental Health Services

The recommendations for mental health services come following significant and ongoing reform efforts. These recommendations acknowledge the success of current programs, such as Police, Ambulance and Clinician Early Response (PACER) and Mental Health Emergency Response (MHER) and a need to equitably adopt these initiatives across the state to better care for patients with a mental health related presentation.

Ambulance Tasmania Redesign

The Ambulance Tasmania Clinical Hub encompasses Secondary Triage, Community Paramedics, Extended Care Paramedics and telehealth services, with a focus on providing safe, effective medical care to meet the needs of lower acuity patients who ring Triple Zero and are assessed as not requiring an emergency ambulance response.

Under the Clinical Hub recommendations, there is a focus on integration with the Care@home and improved pathways for dealing with Triple Zero calls from Residential Aged Care Facilities and those needing assistance for Mental Health related conditions.

Recommendations under the Community Paramedic Program continue to progress as part of the ongoing expansion of the community paramedic skillset. The Department is providing regular monitoring and reporting against both the interim and final recommendations and performance targets, and I am pleased to say progress is being made against these targets which is benefiting both our community and health workforce.

Yours sincerely

Hon Guy Barnett MP
Minister for Health, Mental Health and Wellbeing

29 July 2024

Dr Rosalie Woodruff
Committee Chair
Select Committee on Transfer of Care Delays (Ambulance Ramping)
Parliament House
HOBART TAS 7000

Dear Rosalie

Thank you for the opportunity to add to AMA Tasmania's submission of 13 October 2023 to the previous Select Committee's inquiry into Transfer of Care Delays (Ambulance Ramping).

Since that submission the new Transfer of Care Protocol (TOCP) has come into effect with a staged progression towards a goal of having all ambulances off the ramp within 30 minutes or less. While the AMA supports an end to ambulance ramping, we are opposed to the mandatory nature of the TOCP. With appropriate investment in the right services, access block and thereby ramping would not be an issue.

The reality is Tasmania's health and aged care system is under resourced for an ageing population with increasingly complex chronic comorbidities, sometimes requiring long term care placement on discharge. This under resourcing has led to the growing problem of ambulances being ramped, which is due to Emergency Departments (EDs) being access blocked to the inpatient hospital beds. Patients are suffering due to long waits for care in ED waiting rooms, and there is clear evidence that access block in ED's is associated with increase mortality in patients requiring hospital care. While patients in ED's are suffering, so too are the patients who experience postponements and delays for their urgent and elective surgery. The result is a mounting sense of moral injury, within the workplace among healthcare workers, as healthcare is simply unable to be delivered in the right space for the right patient in the right time.

Transfer of Care Protocol

Nobody wants to see ambulances delayed in attending emergency situations in the community because paramedic staff have been unable to hand over medical care of a patient to ED staff. However, the failure by government to consult properly on the TOCP led the Tasmanian Industrial Commission (TIC) to order further consultation to take place with the AMA and the Australian Nursing and Midwifery Federation (ANMF). While small progress towards a more workable solution was made, it was insufficient to satisfy AMA Tasmania. It remains the position of AMA Tasmania that the consultation process was inadequate as it was limited to the wording of the protocol, and not whether it should be mandated, nor what actions would be required to address the impact of the mandatory transfer of care on ED staff and other parts of the hospital. The fact is, as the mandated TOCP had already been agreed to by government, it was not true consultation and there was no ability to change/ influence the outcome of that fundamental aspect of the protocol. The revised TOCP remains a mandatory transfer of care protocol in all but name.

The AMA and ANMF have repeatedly highlighted the health system issues that have created the ramping problem, as noted in our previous submission. In summary, the problem lies in an under resourced health system that is struggling to cope due a health system that has not be resourced for the current, and the predictable clinical need demand.

The specific issues are:

1. Inadequate numbers of inpatient beds at the acute hospitals: the bed deficiencies are site and region specific and need also to take in to consideration the entire health ecosystem in that area. The specific challenges include:
    a. lack of sub-acute beds for patients who require rehabilitation, and a longer admission for recovery
    b. lack of non-acute beds required for those patients who need to transition from the acute care to home – either aged care facility, or home when they are able to do so with community services support and/or modifications to home for safe discharge etc.

2. Lack of workforce: Inadequate staffing in the THS, combined with the high reliance on locums, impacts on MON-FRI service delivery, even before there can increases discussion around afterhours activity. The workforce challenges include:
    a. Recruitment of Interns to the 3 major hospitals: shortfalls in recruitment result in the THS accepting last minute applicants from within the Australian University Medical School graduates, and/or having to recruit international medical (school) graduates (IMGs) from overseas.
    b. While the IMG pathway has enabled staffing of positions, IMGs require additional supervision. Teaching requirements are variable, can be resource intensive, and can require an extended period of appropriate support and supervision which directly impacts on afterhours rostering.
    c. Registrars: the THS has had a very high reliance on locum registrars. Locum registrars are necessary to fill vacant positions but are also expensive and not always available for the periods required. They also have an orientation/ familiarisation settling in period and are not around to follow up investigations etc when they depart.
    d. Specialist Medical Practitioners: The THS has had significant challenges attracting and recruiting key specialists in many areas, at all 3 major hospitals. This directly impacts on the workload of existing specialist workforce, and being frank, where units are unstaffed and under resourced the focus narrows to patient safety, to ensuring the minimum standards are met in all areas, and self-preservation to prevent patient harm and burnout. There can be no meaningful and sustained evolution of models of care delivery, let alone the expansion of services beyond MON-FRI 0800-1700 in this environment.
    e. Services beyond Monday to Friday 0800-1700 will have very limited capacity to expand beyond this given the current medical workforce staffing challenges and commitments that are needed to be meet in hours, with services beyond this effectively being emergency care

3. Lack of medical investigation capacity:
    a. The THS simply does not have adequate resources to keep up the demand for
        i. medical imaging (Xray, Ultrasound, CT scan, MRI, PET and other imaging) and
        ii. cardiac image investigations – echocardiogram, transesophageal echo etc
    b. These resources deficiencies include inadequate staff to operate the equipment- eg radiographers, sonographers, cardiac echo technicians / sonographers, and inadequate specialist doctors to report the Investigations
    c. equipment, old equipment that's hasn't been replaced and no longer able to be used to report scans (Medicare funded etc)
    d. This is due to a federal government to index the radiology medical investigations adequately which pushes more patients into the "Free" Public health system

e. THS emergency patients, and ward patients, are also in daily competition for access to medical imaging requests
f. Delays in investigations results in delays in diagnosis and clinical decision making, delays in escalation of care, delays in de-escalation of care, delays to hospital discharge, delays in referral to surgery, and patients can suffer adverse events (including advance of cancer from being local to invasive to metastatic, and death) where there is a delay in the diagnosis of a treatable condition.

4. Infrastructure: The future 2040 and beyond plans need to be funded, and commenced to be operational by 2035, not plans that are unfunded and not committed to.

5. **Our ageing population is perhaps the most critical challenge that we need to step up and prepare for:** We have clear data that there is an increasing and sustained growth in elderly patient presentations who will require in hospital care for medical conditions including operations. These patients are increasingly frail and complex. Any assumptions that these challenges can all be mitigated, and therefore require no additional resources, will result in a massive failure of government to plan and prepare for our increasing elderly patient demand. Specific care requirements include:
    a. appropriate spaces in ED – ie beds not chairs, and privacy
    b. appropriate specialists trained in geriatric medicine supporting ED
    c. appropriate investigation capacity to minimise any delays in ED and on the ward
    d. appropriate community aged care teams and access to community geriatricians to be able to provide community geriatric support- to minimise and prevent deterioration for treatable conditions
    e. improving elderly access to GP's when living at home or within aged care facilities
    f. sub-acute and non-acute beds for patients to be transferred into once the initial acute presentation and reason for admission has been treated
    g. appropriate resources and end of life decision making so that elderly patients are not transferred to hospitals when they are in the final stages of life but can be cared for appropriately and with dignity in the community, or the appropriate non acute / palliative facility and not experience a poor and undignified death in the ED's and in acute care hospitals.

6. The THS hospitals are the majority sites for elective surgery, and all have ED's. The constant demand to admit patients is coming at cost of access to procedures and surgery which are necessary. This is highlighted by the amount of public surgery that has been outsourced to private, and the real challenges with the blow outs in category 3 patients waiting for surgery, who are largely complex patients who are not fit for outsourcing to private and have been waiting for months to years longer than healthier patients who have been outsourced to private. These patients not infrequently present to ED needing emergency surgery or with complications from the condition that is yet to be treated.

7. All of these require a health budget that is funded for operational costs and indexed annual for increased demand, and not a budget that is determined by treasury.

Unless these larger systemic issues causing hospital bed block and discharge block are addressed, there will be no end to ambulance ramping without causing other harm to patients who are within the hospital system, and those on the wait lists waiting for their investigations and necessary surgery. The AMA does not see how the TOCP in its current form addresses these issues. The TOCP inserts Key Performance Indicators (KPIs) or targets onto a system that has access and discharge block, and these TOCP KPIs will become impossible to meet without other system reform. We would have been more comfortable with language within a TOCP that said the KPI's are necessary to monitor and report on ambulance ramping, and that the system is then accountable to address the

cause of access and discharge block. Without access, flow, and discharge improvements, the targets are impossible to meet going forward.

As it is, the RHH and LGH hospitals are struggling to meet the objectives and timelines as set out in the TOCP at peak periods. The AMA was willing to work with the government through the TOCP to ensure it was workable and didn't just add further stress to an already overstressed system. However, because of an industrial agreement with Health and Community Services Union (HACSU) requiring a mandatory process, this offer has largely been ignored.

The main change we wanted was to remove the mandatory elements within the Policy. For instance, within the introduction, the words 'Transfer of Care "is" to occur after 60 minutes' and under KPIs the words "with a 60-minute transfer of care remaining the **maximum timeframe** for when it is to occur…" remain which means it still is a mandatory requirement.

The only reason patients will not be transferred at 60 minutes is due to access block. Fix access block and you have fixed the problem. Without appropriate clinical places to put patients and without the adequate staffing to cover those patients, it is dangerous for some patients to be transferred out of ambulance care. We are concerned the TOCP simply transfers risk to an already busy, stressed, and worn-out staff, who when a patient has an adverse outcome while not being attended to, will be made to front a coroner's court to explain why. Patients need to be handed over to the right staff, to care for them in the right space (point of care) and should not have any decrease in care until this has been clinically assessed as being appropriate.

Monitoring ambulance ramping is not a solution - it merely reports the access block being experienced by the ED. It does not measure or report that the ED is providing appropriate care to the patients within the ED. The THS needs the government to provide the resources to improve intra hospital flow and discharge. Indeed, reduced Ambulance ramping is likely to see the same, if not higher volume of patients, presenting to the ED in shorter timeframes, as ambulances are available to respond quicker to clinical cases in the community. Even if the overall volume of presentations via Ambulance is likely to remain the same, it is likely to create a surge or peak in presentations to the ED, which then increases the demand on resources to manage, in a smaller time frame.

The government will point to changes being implemented such as:

1. *Bringing forward each discharge by a few hours, through better discharge planning, communication, and use of criterion-led discharge in and out of hours.*
2. *More use of transit lounges*
3. *Prioritisation of bed cleaning following discharge to enable rapid bed turnaround; this includes review of delays relating to cleaning out of hours and provision of additional resources if required.*
4. *Support from Integrated Operations Centres and inpatient teams to move patients from EDs to wards as quickly as possible, including through use of Interim Inpatient Management Plans as required.*
5. *Prioritisation of diagnostic procedures and attendant/orderly support for transport of ED patients.*
6. *Increasing capacity within our hospitals, through infrastructure upgrades, additional beds, and additional staff over the past two years.*
    - *The 2023–2024 THS bed opening profile was reviewed in late 2023, to ensure an appropriate mix of beds targeted towards areas of most identified need, including to support access and patient flow issues. The agreed profile delivered 68 beds, seven more than the 61 beds required to achieve the 298 bed target by 30 June 2024. The Deputy Secretary HPC has requested hospital chief executives to fast-tack recruitment to enable beds to open by June 2024 at the latest.*
    - *In the South, additional points of care have been implemented in the ED.*

- *The Department is negotiating with the Hobart Private Hospital to secure an additional 15 beds (on top of five existing cardiology beds) to create 20 sub-acute bed access for RHH.*
- *An eight bed GEM Hospital in the Home has commenced in the South*
- *In the North, 11 Hospital in the Home beds will be implemented from early April*
- *In the North West, the capacity of Medical C Ward has been extended to 15 beds*

The AMA notes that these are proposals and plans, and that the implementation of these measures is only part of the solution; ***it is not the entire solution***, and these do not justify or support a mandatory protocol. It is also important to note some of the resources pointed to by government simply do not exist yet to help address the impact of the implementation of the mandated protocol. Others like the additional points of care are in the process of being operationalised or has already been used to help meet preexisting demand, ***not address new demand***. The AMA is also concerned about the ability to use the additional HPH beds effectively.

The prioritisation of diagnostic support for ED has direct impact on inpatients and outpatient diagnosis and flow. This prioritisation only adds to delays for investigations on inpatients, that is those in beds waiting for decisions on treatment options, surgical or non-operative, and delays discharge of inpatients. This impact on patient flow to create inpatient bed capacity, has been omitted in much of the discourse with government. This is a clear example of an unrecognised and unintended consequence from this prioritisation which has been proposed by an Ambulance focused response, not a system improvement to meet all demands on it.

It is critical the Integrated Operations Centre's (IOC's) funding and staffing is maintained to have appropriate decision makers rostered on to ensure that patient flow is continually being monitored and decisions made to prevent and reduced access block. Vacancy control could be detrimental to these management services.

The significant issues of sub-acute, non-acute and aged care facility access block outside of the acute hospital must also be addressed. At any one time, the RHH can have **20 or more** patients who are no longer an acute care patient but are occupying acute beds as there is simply nowhere else for these patients to be cared for. Likewise, the same issues are at the LGH, NRWH, and MCH. In fact, nearly 10% of the total statewide hospital acute bed capacity is occupied by patients needing aged care or NDIS services without appropriate placement options. That's 148 beds that could be freed up tomorrow if there was the appropriate place to move these patients. The patients awaiting NDIS or Aged Care assessment and approvals need subacute and non-acute beds to be transferred into while these approvals are being processed. These NDIS approval processes can take 6 or more weeks to be finalised. There are no clear funded plans to bring these beds online, and yet addressing this issue would have a dramatic impact on patient flow through the hospital. We urge the government to make the new sub-acute hospital facility at St John's Park a priority to help alleviate bed pressure at the RHH.

While work is underway with the National Disability Insurance Agency and aged care sector to reduce discharge delays that are clinically unnecessary, the timelines and outcomes of this are not clear, and as such as no reason to justify any mandatory protocols.

The AMA notes the implementation and expansion of alternative models of care to divert patients away from our EDs and hospitals, including through Hospital in the Home, virtual care/COVID@homeplus, urgent care clinics, direct admission pathways for some patient cohorts, Mental Health Emergency Response and working with the aged care sector to reduce unnecessary admissions from residential aged care facilities, are already underway or are being improved. We support these measures, but again note that these will take time to work up and implement and take effect and require whole of government support, especially from Medicare Funding (MBS items and patient rebates for GP and other specialist care including mental health etc) and Aged Care funding.

The AMA stresses that these are not alone going to be sufficient to address patient access, flow and discharge form the acute hospitals.

We are yet to see several of the recommendations from the *Independent Review of Tasmania's Major Hospital Emergency Departments* implemented to their full extent to see if they have any impact on the issues causing the bed block problem. It is critical adequate additional resources are allocated to assist patient flow throughout the hospital. If patient flow was properly resourced, the transfer of care protocol would not be required. The fact it exists is evidence of the failure of government to address the problems over many years.

Experience since the implementation of the TOCP

The Royal Hobart Hospital:

The ability of the ED to comply with expected TOCP standards is entirely reliant on the hospital capacity to function. A measure of how well a hospital is functioning is the reported escalation level each hospital is at. Escalation levels of 3 or 4 means that the hospital is above capacity and measures are required to improve access and flow. These measures regularly include cancelling surgery and other procedures to prioritise flow of Patients from ED into the hospital, and to get emergency patients needing surgery into theatre earlier, at the expense of elective or booked patients. At levels 1 or 2 they have been largely able to comply. Noting in recent weeks we have moved to a Statewide 3-tiered system. The AMA Notes that the level 4 was specifically created at the RHH because of the pressures within the RHH that lead to "internal disasters or code yellows" being called, and this was politically embarrassing to have the RHH declaring a code yellow.

To improve this, improvement in efficiencies within hospital systems, as well as additional hospital bed stock is needed. But most importantly for improvements to be sustained they need meaningful resolution to hospital exit block i.e. subacute and nonacute bed stock in the community and boosted community services.

Data reporting remains problematic with ambulance reporting seemingly not consistent with data from real time observation and Trak information. To understand the problem, there is a need for investment in clean data capture systems that allow ambulance and hospital systems to transparently talk to each other.

EDs are not choked with GP type presentations. A very small percentage (<2%) of ED presentations could be entirely managed by a GP in the community. The message that EDs are being overcrowded with GP type patients is incorrect. The narrative that urgent care centres are making a meaningful impact on ED presentations is optimistic at best. UCC's may stop around five patients a day going to the RHH ED.

Ambulance offload to the waiting room processes have had minimal effect on TOCP, as this was already occurring at RHH before the protocol.

The reality is Ambulance Tasmania (AT) presentations will not decrease because of the TOCP and access block will continue without meaningful resourcing. RHH senior executives are engaged in seeking access and flow improvements. This is however a very complex task due to under-resourcing, culture and competing service demands. Change will be slow. A protocol of itself is not going to improve access and flow in the hospital and more importantly out of the hospital, which holds the key to the problem.

The Launceston General Hospital:

The Launceston General hospital routinely has patients in ED for longer than 8 hours, and on a daily basis holds admitted patients for greater than 24 hours. With space in short supply, it is not

uncommon to have patients on stretchers in corridors, receiving a lower level of nursing and medical care than is optimal because of the lack of space and staff to provide care.

Following the implementation of the TOCP, the LGH is accepting patients earlier and filling the front end of ED with ED patients. The airlock has become an ED holding bay rather than an ambulance holding bay. Waiting room medicine is becoming a normal activity and extending significant risk into an unmonitored area.

The ED staff have changed their mindset and accept that patients arriving by ambulance or walking in are ED's business. The long stay admitted patients are the problem. But in accepting this responsibility there is an added burden on the ED with increasing numbers of patients waiting in inappropriate clinical areas around the ED and more and more medicine being carried out in the waiting room. This is a compromise in how and where care should be delivered.

There is significant clinical risk in the waiting room as ambulance patients are potentially preferentially off loaded while acute patients wait in the waiting room. The nursing allocations have been changed to support an ambulance triage nurse and an offload nurse. These allocations are dependent on staff numbers on the day and with the significant pressure on nursing rosters staff can be spread thinly around the ED. The LGH has also commenced a nurse navigator role which has been created from existing FTE.

There have been no additional resources to support the TOCP and access and flow initiatives around the hospital. There is significant work to be done in the hospital system to manage access and flow much of which has been detailed in the recent Piccone ED Review. There is an active conversation each day regarding expected dates of discharge, discharges before midday, use of the transit lounge, utilisation of unoccupied HITH beds, district hospital beds, and privates. Despite this the ED is more access blocked than ever with increasing numbers of patients remaining >24 hours in ED. Recently, as an example, there were 14 patients remaining in ED > 24 hours one week and the ED reached 10 > 24 hours in the following week. This is absolutely unacceptable in most ED's on the mainland. As we know this problem is not an ED problem, rather a result of the dysfunctional flow through the hospital and out into the community (exit block). The LGH is by far the poorest performing hospital in the State due to the long stays in ED.

Overall, because of the TOCP there has been some shift in the conversation, but we are yet to see improved access and flow through the system.

The North West Regional and Mersey Community Hospitals:

The TOCP and the ED review have provoked more discussion and focus on access and flow at both sites, however, there have been no new resources allocated to support patient flow initiatives and there has been inconsistent executive pressure on potential levers such as time from previous patient discharge to ED transfer to ward bed. There appears to be a paucity of granular data available to support collective analysis of why patients are not meeting EDD or being discharged early in the day, or why a bed is not available. Early discharges are chronically hampered by a significant reduction in JMO staffing and no redundancy in inpatient registrar capacity. There are large proportions of inpatients who sail far past their EDD due to lack of NDIS or aged care infrastructure to support them at home or in an appropriate residential bed. Weekend discharges remain up to 20% of those on other days.

TOCP cannot occur unless there is a clinically safe space available for the patient. As no additional clinical spaces have been provided, there has been no change in the ED experience following the TOCP implementation. However, ramping has not been as significant a problem in the NW and the NWRH and MCH generally met the initial target. The higher targets will become more challenging.

While the TOCP has not changed the landscape of itself for any of the hospitals, there is a hope that the Picone ED Review will lead to better resourcing and operationalising of services that will address the challenging problem of ambulance ramping with a whole of system lens.

We need to be mindful the data collected around ramping doesn't reflect reality. It is a signal only. For instance, the mean time difference between actual transfer of care (patient physically off stretcher and handover complete) and AT clinician reporting off-stretcher to comms can be quite different, distorting the data. Having consistent collecting of data between AT and ED would help.

Review into the State Hospitals Emergency Departments

The AMA Tasmania Branch met regularly with the primary author of the *State Hospitals Emergency Departments Review*, Ms Deb Picone, to be updated on the progress of the review and to hear our views. The significant challenges facing emergency departments were clearly understood by the review team, however, some of the recommendations to come out of the report are overly ambitious, some only go so far in addressing critical areas such as staffing challenges, and some serious pressure points for our healthcare system have been completely overlooked.

Ask any emergency department doctor about their biggest frustration, and they will tell you it is getting patients admitted into an in-patient bed. Ask any hospital physician, and they will tell you it's not having appropriate sub-acute care beds to move patients into to free up acute beds for the unwell stuck in emergency departments. The human toll of bed blocks is a daily reality they grapple with.

To alleviate the strain on hospital bed capacity, immediate steps must be taken to increase nursing and medical support to residential aged care services, improve NDIS services, and establish integrated primary health care services for individuals with chronic and complex physical and mental health conditions.

The government needs to focus significantly on subacute and frailty care, including bringing forward the building of a new subacute facility at St John's Park. The urgency of freeing up beds cannot be overstated. Many of these sub-acute patients could be stepped down into temporary care facilities while building of a new facility takes place.

We note that issues surrounding aged care and NDIS, from workforce shortages to financial sustainability, are issues primarily for the federal government, but the state can help too in various ways. What we don't want is more finger pointing and inaction.

Where the review has fallen short is overlooking areas of critical shortage of various types of beds and services in Tasmania. For example, while the report acknowledges the importance of expanding the Hospital in the Home or GEM@home programs, (we need at least 100 more beds), it failed to address the implementation of specialised geriatric care in the hospital, a significant oversight given that Tasmania has the highest population of older people in Australia.

AMA Tasmania has put forth a comprehensive plan for subacute and low acuity care implementation. This includes the use of supplemented bed in Medi-hotel environments with recruitment and retention of appropriate staffing, utilisation of community hospitals' subacute beds, and support for patients in their homes by other community health providers.

The review fails to highlight the critical role of all staff in managing patient flow within our healthcare system while also exposing deficiencies in several key areas. These shortcomings include inadequate capacity to manage tests, results, and patient reviews, as well as insufficient staffing across key hospital departments across the state. We cannot afford to focus on flow management and staff governance without emphasising operational aspects to ensure effective and efficient healthcare delivery.

Expanding the scope of practice of other healthcare providers is not the panacea. AMA Tasmania must be involved in any decisions about changes to clinical care provided by other healthcare providers and not doctors. Doctors are highly trained and cannot be substituted by other healthcare providers without increased patient risk. However, where key integrated areas of delivering healthcare in Tasmania work together for instance, Ambulance Tasmania identifying areas where there might be safer and more efficient ways to deliver care to Tasmanians are welcomed.

Record-long wait times for planned surgeries and ongoing challenges in emergency departments underscore the urgent need for action. Access and affordability issues in primary care further exacerbate the situation, with the recent announcement of several key general practices across the state closing or amalgamating adding to the pressure, requiring an improved model of better employment conditions for general practice trainees, funding rebates for patients and improved workforce planning.

We continue to call on the state and commonwealth governments to collaborate to expedite necessary reforms and allocate resources to bridge the funding gap across all services. The only way to fix our emergency departments is to address health system capacity and patient flow through collaboration, innovation, and investment to meet current and projected demands. This is crucial to ensure the delivery of high-quality and accessible healthcare services to all Tasmanians.

RHH ED redevelopment

A threat to the redevelopment plans of the RHH ED has also arisen since the implementation of the TOCP and the release of the Review into EDs. Plans for a major expansion of the RHH's ED have been reduced due to budget constraints and a blowout in building costs.

We understand revised plans are being developed which will see a smaller ED with fewer treatment points being built than initially planned to deal with increasing demand. Therefore, the RHH will no longer have a fit-for-purpose ED that can meet current demand, let alone the increasing demand we know is coming over the next decade and beyond.

Delivering a cut-down redevelopment and using substandard space to compensate is not building the infrastructure Tasmanians need now, let alone in ten years. The last thing we need is for taxpayers' money to be used on a facility that is not fit for purpose.

The reality is that any revision will not deliver the increased ambulance bays required to reduce ramping or the increased number of lay-down beds needed to meet today's demand.

We believe an old ward, known as Ward 3J, meant to be used as a decant space while the redevelopment occurs, will become a permanent part of the ED. This space does not meet modern guidelines for patient safety, patient privacy, and the requirement to be co-located with an ED.

The increase in cost is largely due to nationwide rises in building expenses, as well as complexities associated with constructing on a brownfield site. We need to be clear, any cost-cutting alternative will compromise patient health and put frontline healthcare workers at risk.

Anyone who has been to a public hospital emergency department recently knows they'll be in for a long wait before they will be seen by medical or nursing staff, who are trying to do their best to see patients in an over-crowded facility. A modern purpose-built ED, designed to handle the diverse range of patients who need urgent care, is essential for our healthcare system.

A supportive work environment is not a luxury but a necessity for nurses, doctors, and all medical staff. It enables them to provide patients with the best care and maintain their well-being. It is crucial that their workplace meets the highest health standards.

Healthcare is not just a cost but an investment in our economic productivity. Healthy individuals are more likely to work, contribute to society, and reduce the need for expensive medical interventions. Good health is foundational to a thriving economy.

The AMA can't stand by to watch an expensive substandard redevelopment occur because the government is not prepared to find the extra $50m to finish the project. Investments in infrastructure that supports the health of our community must be the government's priority.

Tasmanian Health Senate

The AMA fundamentally believes that the challenges facing our health service are so complex, broad, and politically dynamic, that it is appropriate for the Tasmanian Health Senate to be given the task to advise Government on what it must prioritise to address access block and enable a non-mandated TOCP within 60 minutes, reducing to 30 minutes, to be achieved over time.

The solutions are not quick and easy political announcements, promises or commitments made at election time, or Enterprise Bargaining deals made between unions and the Government.

We believe the Tasmanian Health Senate should be tasked to oversee the work of the Picone review into ED, as well as ensure recommendations from the Parliamentary inquiry into Transfer of Care are enacted.

In addition, the Senate could identify other issues preventing consistent patient flow through the hospital and work with hospitals to develop and implement solutions to enhance patient flow. These solutions will require a commitment to additional funding from Treasury. Only with appropriate funding of the solutions will we be able to prevent Ambulance Ramping and achieve non mandatory Transfer of Care protocols within a set timeframe.

Medical Workforce

The THS faces significant challenges attracting doctors at all levels, and the complexity with managing and providing a services overly reliant on expensive locums also has clinical risk with lack of ongoing continuity of care, and gaps in service provision. This leads to delays in diagnosis, delays in commencing treatment, and delays in discharge, not to mention the delays in completing administrative tasks which include communication and discharge summaries. Any delays to appointing candidates often sees high quality candidates go elsewhere. Vacancy control has the risk of decreasing the quality of healthcare workers, the quantity of employed healthcare workers, increasing locum reliance and locum costs, and increasing the likelihood of adverse events.

Conclusion

The AMA Supports the introduction of a Transfer of Care Protocol, but this protocol must not be mandatory. The current TOCP still requires mandatory transfer of care of patients to the EDs. Nothing has changed. It is doomed to fail without the resourcing needed to help patient flow. Existing bed floor, executive and ward management staff are already aware and trying to manage flow issues. It is unclear how adding any more pressure onto those key staff will help, other that make for an even more stressful work environment.

The only way to fix ambulance ramping is to for the health system capacity and patient flow to be addressed to meet current and projected demands, through collaboration, innovation, and investment, not a mandatory TOCP.

AMA Tasmania branch supports carefully considered and appropriately resourced initiatives to solve not only ToC but access block more generally. We support non mandated targets linked to improvements in access block and patient flow. The ToC protocol and associated small increases in

resourcing do not adequate address system issues to allow successful or sustainable improvements in patient flow.

We have genuine concerns that without appropriate investment, the TOCP will result in patient and staff harm as well as organisational reputational injury. Therefore, AMA Tasmania branch wants to see ramping of ambulances addressed through:

1. Root cause analysis of Ambulance ramping to identify the Whole of System contribution factors
2. Tasmanian Health Senate to work with Department of Health to develop workforce and infrastructure recommendations to address access block across the hospital system,
3. A clear strategic workforce and infrastructure plan be agreed to by Government Government commitment to funding, resourcing and implementation of the workforce and infrastructure recommendations

Thank you for the opportunity to contribute further to the Parliamentary Inquiry into Transfer of Care Delays.

Your sincerely

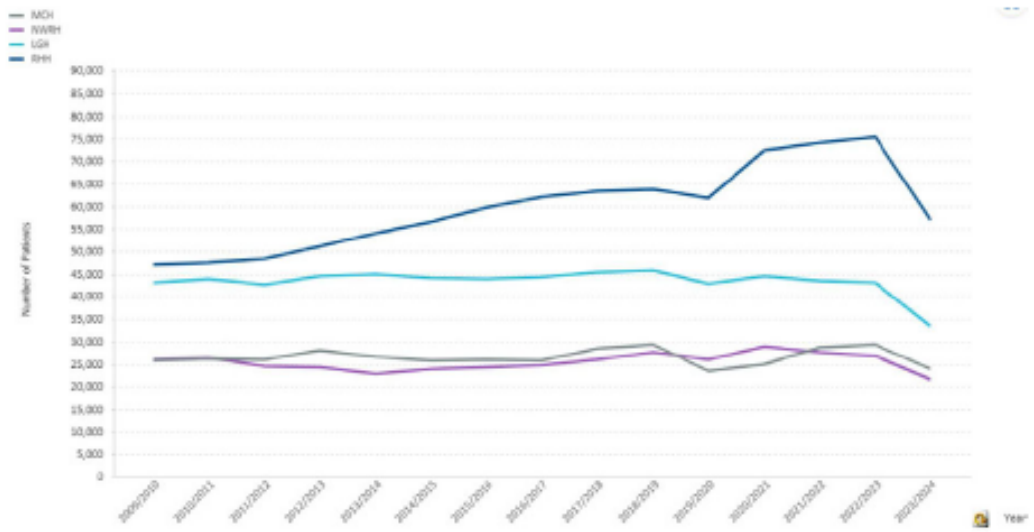
[redacted]

Dr Michael Lumsden-Steel
President AMA Tasmania Branch

Background Emergency Department Data

The following data is important to show the worsening situation in our Emergency Departments – noting the 2023/24 data is incomplete and should not be read as trending down.

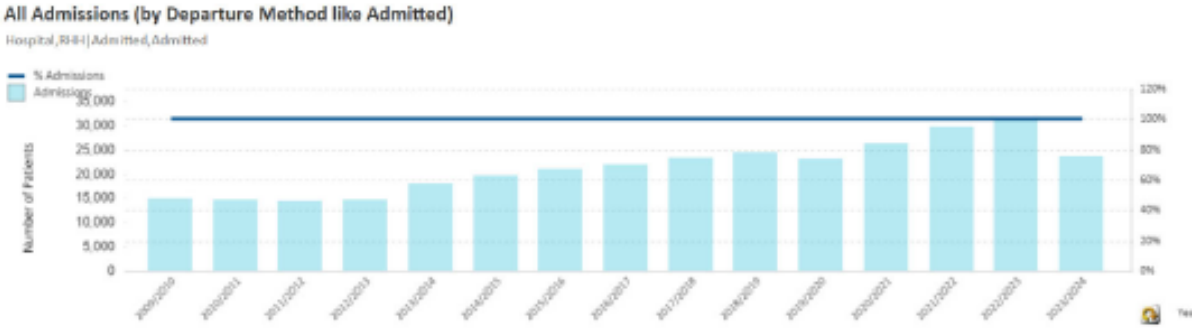
Emergency Department Presentations:



For 2023, ED presentations statewide are approximately 175,000:

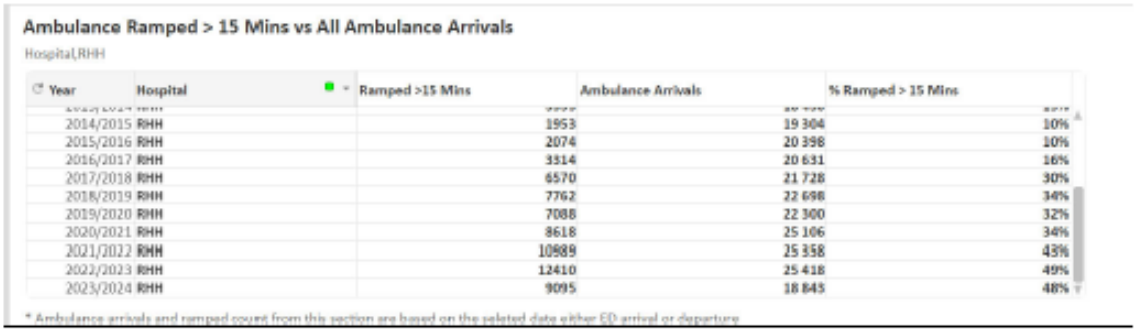
- RHH 76000
- LGH 44000
- MCH 30000
- NWRH 27000

Hospital Admission rates by presentations:



- RHH 40%
- LGH 35%
- MCH 35%
- NWRH 30%

Hospital Presentations by Ambulance:



Ambulance Ramped > 15 Mins vs All Ambulance Arrivals

Hospital,RHH

Year	Hospital	Ramped >15 Mins	Ambulance Arrivals	% Ramped > 15 Mins
2014/2015	RHH	1953	19 304	10%
2015/2016	RHH	2074	20 398	10%
2016/2017	RHH	3314	20 631	16%
2017/2018	RHH	6570	21 728	30%
2018/2019	RHH	7762	22 698	34%
2019/2020	RHH	7088	22 300	32%
2020/2021	RHH	8618	25 106	34%
2021/2022	RHH	10989	25 358	43%
2022/2023	RHH	12410	25 418	49%
2023/2024	RHH	9095	18 843	48%

* Ambulance arrivals and ramped count from this section are based on the related date either ED arrival or departure

The RHH: On average approximately 210 presentations to RHH per day, on average 68 via Ambulance and 145 walk ins. (a 1/3 v 2/3).

LGH – 15000 ambulance presentations per year (average over 3 years) – or 41 per day

MCH 4600 (average over 3 years)- or 13 per day

NWRH – 8600 (average over 3 years) or 24 per day

Time Patients spend in ED:

The data confirms that patients requiring admission are spending too long in our Emergency Departments.

Requiring admission left ED for a ward within 4 hours (running average 2 years): the Expected Target of achieving this is 60%

- RHH – approx. 10%
- LGH – approx. 10%
- MCH – 15-20 %
- NWRH 15 %

Requiring admission left ED for a ward within 8 hours (running average 2 years): Expected Target 90%

- RHH – approx. 40%
- LGH – approx. 30%
- MCH – 50 %
- NWRH 45 %

Requiring admission left ED for a ward within 12 hours (running average 2 years): Expected Target - 100%

- RHH – approx. 55%
- LGH – approx. 50%
- MCH – 50-70 %
- NWRH - 65 %

As a contrast, patients not requiring admission (ie patients ED staff can discharge) are managed closer to the agreed target or exceed it: National Target is 60% have a LOS less than 4 hours

- RHH 58.98 % (Nat Target 60%)
- LGH 52%
- MCH 84.7%
- NWRH 73.20%

The Issues

Australia has an ageing population, and Tasmania's is ageing faster than most, with the result the demand for acute beds is outstripping supply. The AMA Public Hospital Report Card data, backed up by our survey, shows the decline in the number of public hospital beds per 1000 population aged 65 years and over combined with the rapidly aging population is why ramping exists.

Number of approved/available public hospital beds per 1000 population aged 65 and over -all States and Territories

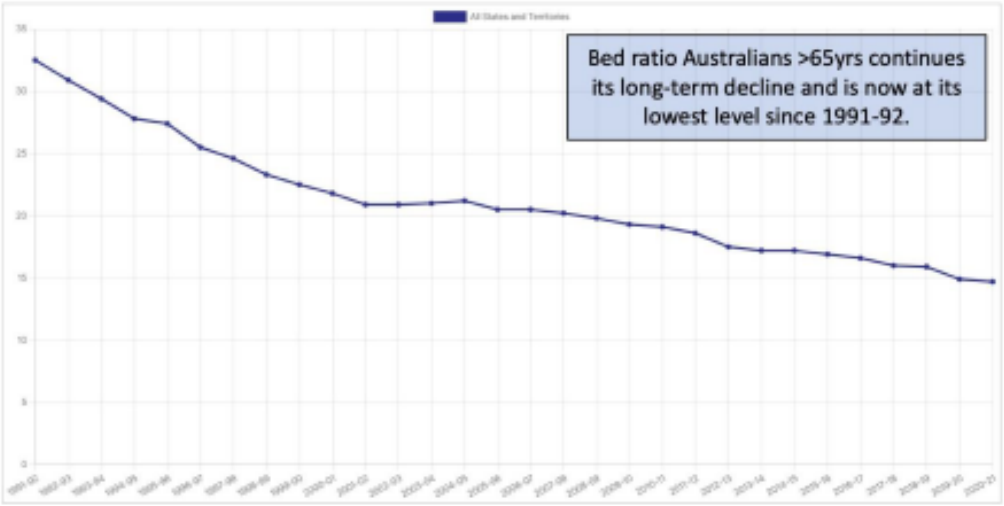


Figure 3: Australian Bureau of Statistics, national, state and territory population, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-download

Figure 3 shows that in 2020–21 the ratio of total public hospital beds for every 1,000 people aged 65 years and older was 14.7 — a decrease of 0.2 per cent from the previous year (2019–20).[14] This is in spite of the fact that overall number of public hospital beds increased by 1.2 per cent in 2020–21 compared to the year before.[15] This ratio has now been on a downward trend for 27 years and is a major cause of public hospital over-crowding and long waiting times for emergency and planned surgery treatments.

To state the obvious, ramping is occurring because the hospital is full. A mandatory Protocol exposes hospital systems that by definition do not have adequate patient capacity to meet demand and therefore impact patient flow. The net effect is a log jam in the emergency department with backflow onto the Tasmanian Ambulance service.

A mandatory Transfer of Care Protocol might achieve ambulances release after 60 minutes, it does not fix the Hospital issues that sit behind the problem of ramping. What it does do is force patients into already full Emergency Departments, adding to the stress of a workforce struggling to give the care required to all in need.

For any TOCP protocol to be implemented and be achievable without compromising patient care or adding more stress to an already stressed system, the hospital and community health system must be appropriately funded. It is imperative that government supports, funds and implements measures to fix access block to ensure the TOCP does not cause more harm than good to patients and staff.

Appendix D: List of previous reviews into ramping

Year	Review	Description
2012 (released 2017)	Monaghan Review	Review of Royal Hobart Hospital Emergency Department patient flow process, including interface with greater hospital and ramping practices.
2014	The Commission on Delivery of Health Services in Tasmania	A report to the Australian Government Tasmanian Government Health Ministers on improving the sustainability of the Tasmanian health system.
2014	*One State, One Health System, Better Outcomes* reform program	The Tasmanian Government's *One State, One Health System, Better Outcomes* reform program focussed on the four major hospitals and defining their roles within the health system. Documents and consultation papers associated with the reforms included a Green Paper, Green Paper supplements, a Green Paper Issues Paper and a White Paper.
2016	Staib, Sullivan and Timms Review	Review of access to emergency care at the Royal Hobart Hospital and Launceston General Hospital. The Review was initiated to inform the Tasmanian Government's *Patients First* initiative (described below).
2016	*Patients First*	A Tasmanian Government Initiative to manage demand in Emergency Departments and improve whole-of hospital patient flow at the Royal Hobart and Launceston General Hospitals.
2017	Review of Ambulance Tasmania	A review of Ambulance Tasmania's clinical and operational services.
2019	Report of the Auditor-General	Analysis of the performance of Tasmania's four major hospitals in the delivery of the emergency department services.
2019	Newnham and Hillis – Towards Outstanding Care at the Royal	An external review of patient access at the Royal Hobart Hospital.

	Hobart Hospital	
2019	Royal Hobart Hospital – Access Solutions	A compendium of occasional papers providing an overview of the issues impeding patient flow and access in the health system, to inform the Access Solutions Meeting on 19 June 2019 called by the Minister for Health and the Australasian College for Emergency Medicine.
2024	Independent Review of Tasmania's Major Hospital Emergency Departments	Independent review into Tasmania's emergency departments and the factors affecting access and flow through public hospitals.

Appendix E - Glossary of Abbreviations

ACEM	Australian College of Emergency Medicine
ACP	Australasian College of Paramedicine
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANMF	Australian Nursing and Midwifery Federation
AT	Ambulance Tasmania
CIN	Clinical Initiatives Nurse
CoG Model	Coordination of generalist palliative care model
CN	Community nurse
COPD	chronic obstructive pulmonary disorder
COMMRS	Community Rapid Response Services
CT	Computed Tomography
DEM	Department of Emergency Management
DoH	Department of Health
ECG	Electrocardiogram
ECP	Extended Care Paramedic
ESCAD	Emergency Services Computer Aided Dispatch
ED	Emergency Department
EDD	Expected discharge date
EMR	Electronic Medical Records
FIFO	Fly in fly out
FTE	Full time employment
GEM@Home	Geriatric medical assessment and management in the home
GP	General Practitioner
HACSU	Health and Community Services Union
HiTH	Hospital in the Home
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
IOC	Integrated Operations Centres
IV	Intravenous line
JMO	Junior medical officer
KPIs	Key performance indicators
LGH	Launceston General Hospital
MET	Medical Emergency Team
MRI	Magnetic resonance imaging
NHS	National Health Service
NASS	National Ambulance Surveillance System
NDIS	National Disability Insurance Scheme
NP	Nurse practitioner
NSAID	Nonsteroidal anti-inflammatory drug

NWRH	Northwest Regional Hospital
PHC	Primary Health Care
PHN	Primary Health network
RACFs	Residential Aged Care Facilities
RACGP	Royal Australian College of General Practitioners
RHH	Royal Hobart Hospital
RDAT	Rural Doctors Association Tasmania
RRT	Rapid Response Team
SOP	Scope of practice
THS	Tasmanian Health Service
ToC	Transfer of care
ToCD	Transfer of Care Delay
TOCP	Transfer of Care protocol
UCC	Urgent Care Centres
WR	Waiting room

Appendix F: Transcripts of Evidence