PUBLIC

THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON MONDAY 5 FEBRUARY 2024

The committee met at 1.30 p.m.

CHAIR (Dr Woodruff) - Good afternoon, members at the table, welcome. Online we have Anita Dow, who is up in the north, and Simon Wood, and at the table, Simon Behrakis and myself.

Before you start giving evidence, I will ask if you received a guide that was sent to you, Mr Emery, from the secretary of the committee, which talks about parliamentary privilege and these proceedings. Just to make a statement to all of you - most of you are familiar - this is a committee of the House of Assembly, and you are covered in what you say here today by parliamentary privilege. That is to enable the committee to do its work. It gives you the freedom to make truthful statements without fear of being sued or questioned in any court or place outside of Parliament. It applies to you while you are sitting here at the table, but it does not follow you out the door, even if you make the same statements outside of here. Do you understand?

WITNESSES - Yes.

Mr JORDAN EMERY, CHIEF EXECUTIVE, AMBULANCE TASMANIA, **Ms KATHRINE MORGAN-WICKS**, SECRETARY, DEPARTMENT OF HEALTH, COMMISSIONER FOR AMBULANCE SERVICES, **Mr DALE WEBSTER**, DEPUTY SECRETARY, COMMUNITY MENTAL HEALTH & WELLBEING, **Ms LAURA PYSZKOWSKI**, ACTING DIRECTOR, OFFICE OF THE SECRETARY, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much. This is a public hearing, and members of the public and journalists might be present and that means that your evidence will be recorded. If there is any part of your evidence that you want to say to the committee in private, you can let me know and we can arrange to go into camera to hear that evidence. Also, joining us online is Lara Alexander. Welcome Lara, nice to see you back.

Mr Emery, thank you for writing a letter to the committee. I want to acknowledge that we received a letter from you on 10 January. You wrote that as an unprompted letter to the committee. In that letter you said your purpose to do so was to address factually incorrect statements and to correct the public record. You submitted that letter as official evidence to the inquiry, and I am going to spend a little bit of time going through it today.

First, where did the idea of writing the letter come from? Was it entirely your idea or was it something that was suggested to you?

Mr EMERY - Dr Woodruff, a discussion took place at the Health Executive Committee about these proceedings more broadly, and if there were concerns about any of the statements made or any corrections that needed to be made, that the relevant business unit representatives - of which I am the business unit representative of Ambulance Tasmania - should correct or write to the committee to correct that record.

CHAIR - It was the chief executive group that made the decision?

Mr EMERY - The Health Executive Committee, which has the secretary and deputy secretary and chief executive group.

CHAIR - Okay, so you were asked to write to the committee to correct the record?

Mr EMERY - I wasn't specifically asked, but we discussed at that meeting that if we thought that there were statements that were incorrect, that they should be corrected with the committee directly by the relevant chief executive.

CHAIR - Was the writing of that letter to this committee suggested to you at that meeting?

Mr EMERY - I don't recall, Dr Woodruff, if the writing of that letter specifically was, but I do recall that we discussed it a short time after that evidence was given in the committee, and so there may have been a discussion specifically about an Ambulance Tasmania response, but I was aware that some of the information that had been provided I didn't consider to be factually accurate.

CHAIR - Thank you. In your letter you mentioned one of your employees by name on eight occasions. Why did you think it was necessary to repeatedly name one of your staff in such a way?

Mr EMERY - I am assuming you are referring to Mr Posselt?

CHAIR - It's the only name you have mentioned in the letter, and you mentioned that person eight times in the letter.

Mr EMERY - Perhaps just for completeness or to be thorough, there was certainly no ulterior motive in naming Mr Posselt.

CHAIR - Can you see how it could be taken the wrong way? How it could be seen as an attempt to intimidate a member of Ambulance Tasmania who was speaking out? To be clear, I've already had feedback from paramedics that your naming of a staff member in a letter in that way had felt exactly like that for them.

Mr EMERY - If that is the case Dr Woodruff, that is deeply regrettable. I would never seek to intimidate the submission of a paramedic to this Committee or indeed speaking about matters of public interest.

CHAIR - Your letter repeatedly names this staff member in the context of your claim that factually incorrect statements had been made. Can you see how it might feel to someone like it's an attack on their integrity, especially given that they were required to swear an oath to us of honesty in the evidence that they gave to the committee?

Mr EMERY - Dr Woodruff, if that's the impression I've given in my submission, then I am sincerely sorry. That is absolutely not my intention.

CHAIR - In your letter you say that that staff member gave evidence to the committee on 12 November, which to start with is not correct because there was no hearing on that day. You then quote the staff member as having said to the committee during the evidence that, 'Every hour there is a P1 P0 case that gets no response'. I've carefully reviewed the transcript of that hearing of the committee and that quote doesn't exist. This person does say, 'Almost every second hour there is an emergency call without a response'.

That is quite a different statement. In your letter, which was designed to correct the record that repeatedly names one of your employees, you have misquoted them and then you've used that misquote to suggest that their statements made under oath were not true. How could that have happened?

Mr EMERY - It's clearly an error by me Dr Woodruff, but I do want to restate that I had no intention of intimidating an employee who made statements to this committee. I mean it sincerely when I say that I deeply respect Mr Posselt, and whilst I don't agree with some of the information he provided and that I don't consider to be factually accurate, I would never seek to intimidate an employee away from making submissions of matters that are in the public interest.

CHAIR - I found it remarkable that when you were refuting the claim in the letter - which is misquoted, as we have already established - your letter says Ambulance Tasmania, 'Believes the statement that an emergency call going without a response every hour is not correct'. Do you have a record of the frequency of emergency calls that don't get the immediate response they are supposed to have, or is that just a gut feeling you have?

Mr EMERY - Dr Woodruff, this committee wrote back to me on 25 January 2024 seeking a number of clarifications about my correspondence dated 10 January. I am in the process of finalising that for you. Unfortunately, a number of the questions asked of me required us to analyse manual data, but I will be able to provide a comprehensive response to the committee in response to your letter dated 25 January.

What I would say in relation to one of the questions is clarification in that letter about what constitutes an immediate response. The target that we work towards in terms of assigning an ambulance to a priority zero (P0) or a priority one (P1) case is an assignment of an ambulance within three minutes. That's because when someone calls 000, they go through our medical priority dispatch system and respond to a number of scripted questions. As they go through those questions, what we call a medical priority dispatch system determinant is applied and that determinant aligns with what type of ambulance response they will get, so more serious cases have a more urgent ambulance response.

What we know from our data in the time period requested, 2022-23, is that 75 per cent of priority zero and priority one cases are assigned an ambulance within three minutes and when you increase that to five minutes, which would be two minutes over our intended target, 91 per cent of priority zero and priority one cases are assigned an ambulance within that time frame.

CHAIR - You don't actually have the data to back up that claim; that's a different sort of data that you were just referring to. How could you make a claim refuting the statements by that staff member if you didn't have the data to back it up? You don't specifically have data to refute his claim. How could you make a claim that that person was wrong?

Mr EMERY - I take your point, Dr Woodruff. I guess what I am saying is that when you look at the totality of priority one and priority zero cases, the vast majority are assigned an ambulance within that three-minute window.

CHAIR - That may well be true, but this person was talking about the priority zero every hour. You said, 'every hour', and we know that was misquoted. The person said almost every second hour there's an emergency call without a response. That's a very different statement to the one you refuted, and you have just clarified, I believe, that there isn't evidence to back up that statement. You said you 'believed' that it was not true.

Mr EMERY - I take your point, Dr Woodruff, but I would have to go and look more specifically into the data. I understand that.

CHAIR - The committee has heard from multiple paramedics, we have heard from the unions, we have heard from ambulance dispatchers that having no crew available to respond to an emergency call has become a frequent event. It is a matter of deep distress to the people who have presented evidence to this committee. We recently heard the case of a Monday night where there were eight or nine such cases during one dispatcher's shift, and this person said to us it happens regularly.

Do you accept what your staff are telling us that this situation, where there are delays getting an ambulance response to calls that have been designated by experts as an emergency has become a frequent event?

Mr EMERY - It's absolutely a problem, Dr Woodruff, and it's not just a cause of distress for my emergency call-takers, emergency medical dispatchers and paramedics; it's a source of distress for me as well, as the chief executive. I care very deeply about my solemn obligation to deliver ambulance services to the people of Tasmania, especially during life-threatening emergencies. There certainly are cases where we do not have an ambulance available to respond to a P0 or P1 case. That is why I, alongside my health executive colleagues, have done a lot of work to develop the urgent offload protocol and a range of other initiatives to do everything we can to free up ambulances to respond to emergency cases in the community.

CHAIR - You do believe now what your staff have been telling us?

Mr EMERY - I believe that there are occasions, and sometimes several occasions, where we have priority one and priority zero cases where we can't allocate an ambulance in the target time frame. Even to the statistics I quoted just then, it would still mean that 25 per cent of cases don't receive an ambulance within the desired time frame. There are a range of different reasons why that might happen, but I'm doing everything I can, along with my health executive colleagues, to try and address those issues.

CHAIR - I think there are five emergency incidents every hour in Tasmania, on average. You said before that 25-30 per cent of them aren't getting assigned within three minutes. That's one-and-a-half calls every hour on average and one every two hours that isn't assigned within five minutes. That sounds like a pretty reasonable ball-park estimation of what's happening, which is exactly what that staff member gave evidence about to the committee. Do you agree that that's a fair and reasonable assessment of the current situation?

Mr EMERY - I'm happy to accept that point, yes, and I'm happy to look more deeply into the data and seek to understand and report back to this committee if that would be helpful.

CHAIR - That would be helpful, thank you. We can get back to you on that.

Mr Emery, the report on government services data released last week showed 44 000 emergency incidents dealt with by ambulances in Tasmania in the 2022-23 year. It also showed that the 90th percentile emergency response times for ambulances was 35 minutes, and that figure has rapidly increased in recent years. This means - for people watching - that there were 4400 responses that took 35 minutes or more. With the number of cases we're talking about now, and how much longer they're waiting, isn't this situation highly suggestive of frequent events where ambulances aren't able to immediately respond to emergency calls?

Mr EMERY - There are a range of different factors that contribute to the median response time and the 90th percentile as well. Of course, a rising demand for ambulance services is putting pressure on the resources we have available to us. Of course, the availability of ambulances is pressured when they experience transfer-of-care delays or a range of other factors that might reduce the availability of ambulances in the community.

CHAIR - You're making a statement that there aren't the resources available at the moment to be able to respond to the urgency and frequency of calls you're getting?

Mr EMERY - I think what's clear from the report we commissioned by Operational Research and Health is that we would like to have a target median emergency response time of 10 minutes in urban areas and 15 minutes in rural areas. We are not currently achieving that, which is why we have put together a comprehensive business case for additional staffing over the next 10 years to address that response performance.

CHAIR - That sounds good. We've got 4400 responses in a year that have seen these big delays in emergency responses. I'll point out that there's just under 8800 hours in a year, so we have one of those cases occurring every second hour. I will remind you that the suggestion that was made to this committee by a member of your staff was that there were delays to ambulances being dispatched for emergency response almost every second hour. Given the figures, do you agree that that is a very reasonable claim that was made by one of your staff members?

Mr EMERY - Yes.

CHAIR - Thank you. Going back to the letter, you wrote to the committee and said you wanted to correct the public record. You also took issue with evidence given about overtime hours, and you wrote that the staff member in question stated that, 'Paramedics anecdotally report one to two hours overtime after completing a 12-hour shift', and that this practice is a completely normal and expected part of the day. You went on to say, 'This statement is not accurate'. What was the basis of your claim? What was the evidence for your claim?

Mr EMERY - The basis of my claim, Dr Woodruff, related specifically to the notion that all paramedics work one to two hours after completing a 12-hour shift, but I accept that there may be different interpretations of the statement Mr Posselt said. I interpreted that statement to mean that every paramedic is expected to work one to two hours.

CHAIR - You said that the statement is not accurate. It sounds like this is another case of making a claim that something isn't accurate without knowing whether it's the case or not. There doesn't seem to be readily available information about the number of shifts that are running overtime. Is that correct?

Mr EMERY - There are some limitations to compiling that data comprehensively because of our manual rostering system. Yes.

CHAIR - How are you so sure that it was an incorrect statement?

Mr EMERY - Because I interpreted the statement to mean every paramedic works one to two hours of overtime every shift.

CHAIR - But that's not what that staff member said. That staff member said paramedics anecdotally report one to two hours overtime after completing a 12-hour shift, and that that practice is a completely normal and expected part of the day. They didn't say every single shift, but it was a normal practice that occurs on a regular basis, that is how I read it.

Mr EMERY - Okay. I accept that point, Dr Woodruff.

CHAIR - Okay, because I think it's important to - again - point out that this overtime situation isn't just a claim that's being made by one paramedic. Five years ago, we had a large number of paramedics in the state's south who wrote to your predecessors claiming about overtime being a key issue, and what we're being told - this committee - is that it's been all downhill from there. The committee has heard consistent evidence from paramedics on that front. With that in mind, do you acknowledge that the evidence given to this inquiry about paramedic overtime is completely reasonable and fair?

Mr EMERY - Dr Woodruff, I absolutely accept that the workforce is working additional overtime, and if I can speak candidly with you, it's a source of concern that some of the questioning might suggest that I'm in disagreement with my workforce about the very difficult challenges they face in their role. I absolutely accept that the rise in demand on ambulance services, the increasing community outreach for ambulance services, for members of the public who have difficulty accessing primary care, the population growth and other factors driving demand for ambulance is contributing to longer shifts for my paramedics, greater workload. I absolutely accept that entirely.

CHAIR - You understand the reason I'm asking these questions is because you wrote this letter. We didn't ask you to write this letter. You wrote a letter, and, in the letter, you make one, two, three, four different issues with things that have been said to this inquiry under sworn testimony by members of your staff and you say that they are claims and that they are inaccurate. You understand why it's very important for the committee to get to the bottom of whether you think there is information that has been provided to this inquiry that is incorrect?

Mr EMERY - Of course, and I don't take umbrage with you asking the questions. I would not want an impression to be formed by you or this committee that I don't have a deep regard for my workforce and the very significant challenges they face in their role, and I work every day alongside my executive colleagues to try and support our paramedics and drive changes within the system so that they can go home to their families after their very dedicated service every day.

CHAIR - I know that there are other members of the committee who need to ask questions. The final part of a letter that we have been discussing which, again, refutes evidence given by a particular paramedic to this committee. You say the idea that paramedics have been expected to complete some elements of their mandatory training packages while they are ramped is inaccurate.

I am sure it will be Ambulance Tasmania policy for this to happen, but that was not the point that we heard being made by the person who gave evidence, or by the people who have given evidence. The point was that due to the relentless workload on shift, including being on the ramp continuously, there is often no other time available for this training to happen. It has created a situation where managers have felt like they have needed to ask people to do this work while they are ramped.

I would also remind you that in their resilience survey conducted across your organisation in 2021, 84 per cent of respondents in Ambulance Tasmania staff reported they felt, 'A sense of threat from managers'. Do you accept that, at the very least, such a situation occurring is plausible pressure to undertake the completion of mandatory training packages while ramped?

Mr EMERY - Yes, Dr Woodruff, it is plausible. Let me be emphatic on the record, there is no requirement for any employee, ramped or otherwise, in a phase of providing patient care to undertake mandatory training. No requirement at any time during the provision of patient care, including while they are ramped, to undertake mandatory training.

CHAIR - Do you think it is possible that people are feeling strong pressure to do that, regardless of the fact it's not a written down protocol?

Mr EMERY - If the submissions have that people feel that pressure, I would be foolish to refute that, but they should know emphatically that is not my expectation as the Chief Executive, and I will be very clear with our leaders across the organisation that is not an expectation that should be communicated to any paramedic.

CHAIR - Before I move on to another member, what we have got here, Mr Emery, in the letter that you gave to the committee to summarise, to correct, you have written it as a letter to correct the public record you said on testimony, given under oath by one of your staff to this committee, and in the course of this letter you repeatedly named your employee. You misquoted them and you provided no evidence to back up your claims. During today's hearing you would agree that you have been unable to substantiate the points that you made in the letter, in fact, you even admitted that the substance of the claims that have been made were valid.

Before I move on, I want to give you the opportunity to apologise to your staff for what, I'm sure, were innocent mistakes. If you would like to do that, that would be appropriate.

Mr EMERY - Dr Woodruff, a couple of quick points if I may. I think our subsequent will provide some more substantive data following the follow up questions by this committee. I will make two statements, if I may. One, I apologise unreservedly to Mr Posselt in respect to the statements made in my corresponding letter. Secondly, I absolutely reject any suggestion that I would ever intimidate an employee. I lead some of the best people in Tasmania, and I have enormous regard for them and never, ever would I seek to intimidate or threaten or deter

them from making statements about matters that are in the public interest in my role as the Chief Executive.

CHAIR - Thank you for that, and it is possible that you got some bad advice. I am going to pass on now to Ms Dow, who has been waiting patiently.

Ms DOW - Thank you, Chair. I would concur with that; it does look as though you got some poor advise in putting that letter together. It would have been great for the committee to have that data that you are going to send to us as further evidence of information that you have provided to the committee. I want to take you, Mr Emery, to the fourth issue that is raised in that correspondence that you sent to us about there only being - on Saturday night, 9 December last year - only 40 per cent of the night shift being covered. I want to ask you if you looked and reviewed the master data for that evening before providing those comments?

Mr EMERY - Ms Dow, I sought advice from my leadership team in relation to rostering. I take full responsibility for signing the letter and am responsible for ensuring the appropriate assurance of the correspondence that was provided to this committee. I didn't specifically review the master myself. However, in an updated letter that is going through the approvals process, I make a slight correction to the percentage I provided in this report, and I specifically address a matter pertaining to two staff members who finished shift in the urban area at midnight, which I wasn't aware in my submission to this committee on 10 January.

Ms DOW - Did you review the master data before providing that further information to us?

Mr EMERY - Yes, I did. I met with my team on Friday of last week and personally reviewed the masters.

Ms DOW - I think it's important to put on the record that it is disappointing that further information is coming back to the committee and information that was provided wasn't accurate. We had to question it.

The other thing I wanted to talk to you about is staff shortages across the ambulance service. You referred to the government's own report, which calls for 126 paramedics to be employed across Tasmania. In the business case that you've put forward, how many paramedics have you requested for this next coming financial year to be employed across the health service?

Mr EMERY - For this specific financial year forthcoming, Ms Dow, if I could have a few moments to look up that number on the report itself? I just don't have that exact number off the top of my head.

Ms DOW - Sure.

Mr EMERY - The report proposed 126, as you said, over through until 2032. What we've proposed in financial year 2024-25 is 33 paramedics spread across the state, predominantly focused on the south. Some of that is because the recommendations in the report relate to new stations, as you'd be aware, at Snug, Cygnet and Sandy Bay, where we don't currently have infrastructure and would need to do some work around the infrastructure. We seek to increase that number - sorry, we seek to recruit additional paramedics year on year.

On top of that, there are a range of other critical support roles, which includes business support officers, operation supervisors, paramedic educators, et cetera, to support those clinicians.

Ms DOW - Thank you. My next question goes to short-term contracts for paramedics across Tasmania, which we understand is a significant issue when it comes to retention and attraction. Can you please tell me how many paramedics, broken down by the north, north-west and the south, are on short-term contracts, please?

Mr EMERY - Ms Dow, if I could provide that information on notice, I would appreciate the opportunity to do so. The reason I am a little unsure of the numbers is because we have a new class commencing next week, in which, I believe, we are bringing in 18 additional paramedics, and a number of individuals have just recently been converted from fixed-term to permanent positions. I just do not have that exact number off the top of my head, so if I could provide that on notice, I would appreciate that.

Ms DOW - Thank you. I have one final question, Chair. We understand that there are issues with ramping that evolve from inter-hospital transfers, and it has been something that has been raised with this committee. I would like you to address that and whether there are any policies or procedures being put in place to ensure that those patients who are transferred between hospitals in Tasmania do not find themselves ramped, don't have to present to an emergency department and can be admitted another way to decrease pressure on the emergency department paramedics.

Mr EMERY - Thank you, Ms Dow. There was a policy that we established with the support of the Secretary for Health, the Inter-Hospital Transfer Policy, that was released in October 2022 that was specifically designed to ensure that patients who were in inter-facility transfer between another hospital did not experience transfer-of-care delays in the emergency department. We know that there still have been occurrences where that has happened. We have predominantly seen that in the north-west, Ms Dow, and I suspect that is why you are acutely aware of it, because we see patients moved from Mersey Community Hospital and North-West Regional Hospital over to Launceston General, and that is where they may experience those delays.

An updated version of that policy was further circulated in November 2023, and I worked closely with the chief executives of the respective hospitals, because it's important for me - and indeed, the secretary and deputy secretary - that those patients are not experiencing transfer-of-care delays when there is a ward bed available for them.

Ms DOW - Thank you, thanks Chair.

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 per cent 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.

CHAIR - I suppose one of the things we have heard from a number of paramedics in open testimony has been a sense of devastating stress and mental suffering from the rapid pace of change in ambulance ramping, the increasing length of time in ambulance ramping, as well as the impacts it's having on patient outcomes on the ramp and their incapacity to be able to respond to 000 calls they can hear. In that situation, why have you just employed one person, but you are not taking the temperature of the staff? And what are the opportunities for getting feedback from your staff right now? How do you know, as someone who is new in this role, what your staff feel about the situation they're working in? You don't have an indication, do you?

Mr EMERY - No, I don't want to sound egotistical, Dr Woodruff, I spent an enormous amount of time with my frontline team, I worked on-road on New Year's Eve, I was in Launceston meeting with my team last week. I pride myself on being incredibly approachable and I consider myself to be a deeply compassionate leader who cares deeply for my people. I make every effort to seek and listen to their concerns, and not just listen to their concerns but act on them. If you look at a range of different initiatives I've sought to implement with the support of the secretary and deputy secretary since I commenced with Ambulance Tasmania in January 2022, I am laser-focused on doing everything I can to address transfer-of-care delays. I know it has significant impacts on the wellbeing of my people, not just whilst that delay is taking place but also whilst they feel unable to respond to other emergencies in the community. That is an experience shared by their nursing and medical colleagues as well.

CHAIR - It is not the role of this committee and wasn't my intention to make any assessment or negative statement about you and how you conduct your job. What we found as a committee is that there is a lack of data available that is being collected, both by the THS and Ambulance Tasmania, to provide the evidence to make the changes needed to respond to situations. I just wanted to clarify for the committee that there was that survey in 2021 and there was another survey in 2022. Things have changed substantially on the ramp, there has been a lot more pressure, but at the moment there has been no extra information in data form

that Ambulance Tasmania has about overall staff satisfaction and concerns in the workplace. Is that correct?

Mr EMERY - Other than the Tasmanian State Service Survey that was published six months ago or so.

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 time line?

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.

CHAIR - Have you finalised a position on the mandatory psychological support? I believe there might be a range of views about whether it is psychological support or psychological assessment. I recognise they are quite different things. Do you want to comment?

Mr EMERY - I think that is an important distinction, understanding a psychological assessment versus wellbeing check-ins or other processes. I do not think that is just semantics, to your point; I think they are quite different things. We are also looking at that, alongside mandatory drug and alcohol testing; the two recommendations. We are not absolutely hand-in-glove, but we see synergies between the two in terms of how we might roll that out. We want to ensure that we consider that fully and consult fully before we would go about implementing that.

CHAIR - How long ago was the coronial inquest finalised and those recommendations produced?

Mr EMERY - The inquiry was handed down in July 2023, so five or six months ago. I have had a number of meetings with Ambulance Victoria, which has mandatory drug and alcohol testing in place, and a wellbeing support framework around that. We have also met with New South Wales Ambulance, who are embarking on a similar body of work at the moment to try and understand where there might be opportunities for learning what that might

look like. We are working closely with the office of the secretary around next steps and what that might look like.

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.

Mr WEBSTER - If I may, Dr Woodruff, there is already in place the MyPulse, which is a program for emergency services. It is a shared program between Ambulance Tasmania and the Department of Police, Fire, and Emergency Management. There are three levels of support from within that program: the wellbeing support officers across Ambulance Tasmania, which is very short-term, refer you on; the peer support officers who receive a level of training and can support you; but also, the critical incident stress management which is available as well through that program. That program has been in place now for a number of years, it has been funded and is across all emergency services. In terms of support programs, they are there. Whether you then add -

CHAIR - Are they person-to-person?

Mr WEBSTER - The critical incident stress management is, and the peer support is, and the wellbeing support. In fact, all of those are person-to-person. But, obviously, each one of those is done at wellbeing. You are at a different level of support through the critical incident stress management.

Mrs ALEXANDER - Thank you, Chair. My question is for the departmental secretary, Ms Morgan-Wicks. Because the two issues are very much interrelated in terms of ambulance ramping and transfer of care, I noticed that in 2017 there was a review of Ambulance Tasmania and one of the recommendations was that there should be shared clinical governance of the patient's journey into the emergency department by both Ambulance Tasmania and hospital EDs. Since that is almost seven years ago, could you please elaborate what sort of clinical governance we have and how much progress has been made on that recommendation, because I do believe it is critical for continuity of care?

Ms MORGAN-WICKS - I might make an attempt to answer, noting that I am not a clinician myself, but I can refer also to the chief, who has clinical directors reporting to him. We also have our chief executives of hospitals, noting the significant work to bring together a single patient medical record that is available and to be viewed between both paramedics that are responding, from call-taker through to paramedic responding to an address, through to the

emergency department and beyond, which has been a significant focus of our Digital Health Transformation work. I can elaborate a bit further on that because we are coping with the technology we have. Certainly, in 2017 there were several references to the technology not being shared, let alone the clinical governance on top of that. I might ask Jordan to respond from a clinical governance perspective. We could also invite up a chief executive of one of the hospitals if you would like to hear further from that.

Mrs ALEXANDER - Yes, I am quite interested, thank you very much.

Mr EMERY - Thank you, Mrs Alexander. Clearly, our view, and the view we work closely on as a health system, is that there is not an Ambulance Tasmania patient and a Tasmanian Health Service patient: when Tasmanians seek the assistance of Ambulance, they become a patient of the broader healthcare system, and we all have a shared clinical governance obligation in terms of the care we provide to those people.

There are a range of systems in place within the emergency department, though there have been challenges around clearly delineating care where the commencement of a certain procedure might be inconsistent with a paramedic's scope of practice. In any event, we have sought to clarify that by ensuring that the initiation of treatments and the monitoring of patients outside of paramedics' scope of practice is fully supported by nursing and medical staff if that patient is experiencing a transfer-of-care delay.

Periodically, when safety events have occurred, we work very closely with our colleagues in the THS and co-participate in what we call safety huddles, or root-cause analyses, which are part of our comprehensive statewide clinical governance framework to manage safety events or patient incidents within the healthcare system. If Ambulance Tasmania is involved in those, of course we participate in them as well.

Mrs ALEXANDER - Thank you for that. I am struggling to get the picture. What you are telling me is that basically some work has been done around that shared clinical governance of the patient's journey and some work has been done following that particular recommendation. Is that work broad or is it more of a strategy that is available for us to analyse further? I am trying to match the actions you describe with a particular set direction and following a particular set of clinical governance. Is it broad, is it like a moving situation or has it got a particular plan that you are following around the clinical governance?

Mr WEBSTER - Looking at this, the first thing is the restructure of the department that occurred in 2019 brought Ambulance Tasmania into a division of the department and, through that, also included Ambulance Tasmania joining the clinical executive, which is a health-wide executive so they have input into the clinical policies, or clinical governance policies and protocols that are developed by the department for the THS, or by the THS and the department. The most recent iteration of the Tasmanian Health Service Plan includes key performance indicators that are joint for Ambulance Tasmania and the hospitals, so it's about that integration. But a number of key protocols that have been developed, particularly over the last two to three years, are joint protocols. Mr Emery has already spoken about the hospital transfer protocol. There is also the urgent offload protocol which exists between the Royal Hobart Hospital and Ambulance Tasmania, and a similar protocol for the LGH. There's development of health relationship managers within AT to manage relationship between the hospitals and the ambulance.

We have also implemented across our hospitals over the last few years integrated operation centres (IOCs). They have access to the information Ambulance Tasmania has on its boards about the flow of patients, so the flow of patients in the IOC can be monitored from the point of a dispatch of an ambulance through to arrival at the ED and then, if they require a bed, up into a bed and, in fact, into discharge as well. It is about integrating our system so that the patient coming into AT is seen as a patient through the whole patient journey. That's the broad strategy, but it requires lots of inputs.

I think the other critical role which has been put into Ambulance Tasmania since 2020 is the role of an executive director, clinical services. Again, it is making sure that AT are inputting into the clinical executive and clinical governance of the whole patient journey.

CHAIR - Thank you. Ms Dow, did you have another question? We are nearly out of time for Mr Emery.

Ms DOW - Mr Emery, why can't you fill shifts at Ambulance Tasmania?

Mr EMERY - I think there are a range of different reasons. One is we have some true vacancies, as I would call them, so vacant roster lines within the north-west of the state that we are actively recruiting to at the moment. It has been challenging to fill some of those shifts. As you are aware, they were initially COVID-19-funded positions and there were some challenges having people relocate to the north-west of the state on a fixed-term basis. However, we are working to fill those vacancies. We do have some challenges periodically filling those vacancies in certain locations or remote locations across the state.

Like all organisations, we experience sick leave, we see an increasing amount of our workforce seeking flexibility because of parental or older parent carer obligations. There are a range of different reasons that contribute to some of our roster vacancies on a shift-by-shift basis.

CHAIR - We have also heard from people who have given evidence to the inquiry, paramedics, that because of the intensity and stress of sitting on a ramp during a shift, particularly on busy nights where there are 000 calls that go unanswered - and they can hear that on the ramp - then they do overtime after a shift, that they just can't turn up to the next shift. You will have people who are not able to meet all of their rostered nights in a row because they are simply too emotionally drained. Is this a situation you are also familiar with?

Mr EMERY - Yes, it is a situation I'm familiar with and it was a situation I was familiar with during my leadership roles within New South Wales Ambulance. 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.

CHAIR - Thank you, Mr Emery. The time is almost up. Mr Webster, a final question to you. In last year's Budget Estimates, you were of the belief that ramping data was already published on the HealthStats dashboard. I remember asking you questions about ramping data, and you told me I should just check the website. We have been told monthly ambulance ramping data is already recorded internally. Why is it not published publicly?

Mr WEBSTER - Dr Woodruff, thank you for that question. At Estimates we did say we published data on waiting times and transfer-of-care delays as part of our dashboard, and we do that. You did specifically ask for more detailed data in that. We are constantly updating our dashboard with new data as we are satisfied with the veracity of the data and those sorts of things. We do not want to start publishing data that is incorrect. Yesterday the minister announced that we will be putting up data about emergency department waiting times from tomorrow.

All of those sorts of improvements will occur over time. I probably in summarising would say to you that we are absolutely focused on getting rid of transfer-of-care delays. That is why the department and the government agreed with the Health and Community Services Union to introduce the mandated transfer policy that would commence later this year. But in addition to that, that is why we have worked with the hospitals and Ambulance Tasmania for the Inter-Hospital Transfer Policy that Ms Dow highlighted. It is why in response to not being able to do the triple 0 calls -

CHAIR - Just on the data, we do not have long, from what I hear you saying, that you would be comfortable with publishing more data if the committee were to find that there may be value in more information, that's already collected, so that it provides Tasmanians with the best possible information about the risks, the adverse outcomes and the other matters that help us as a state to better understand the impacts on the health system from ambulance ramping?

Mr WEBSTER - Yes, we would, Dr Woodruff. In response to that, the record is that we have been doing that and the dashboard has been expanding over the last few years with additional data as, A, we find it helpful for the public to have, B, we understand the veracity of the data so that we are not publishing information that could be misleading.

Ms MORGAN-WICKS - Dr Woodruff, if I may add, we have also substantially increased the number of key performance indicators in our service plan, which is published and tabled in parliament. Certainly in relation to the performance of each of our operations, I know in the last hour we have focused very heavily on ambulance, but noting that from my perspective as secretary, but also commissioner for ambulance, the work of our chief executive, Jordan, and the work that he has done to get into the hospitals and to get into the EDs and to actively engage with our chief executives, and sometimes some quite difficult and confronting conversations to really advocate on behalf of his workforce, has been outstanding in my view. Certainly, in seeing that work come forward, and often it can be a very difficult conversation that occurs between the different objectives between an emergency department, but also the presenting ambulance team. We know we have a lot more to do, so we are absolutely clear on that, but I just wanted to note in terms of Mr Emery's really hard work and perseverance, he came to the state in mid-2022 in very difficult circumstances through the pandemic and has continued, is passionate and positive about really trying to improve our ambulance service.

CHAIR - Thank you, Ms Morgan-Wicks. We have to finish up with Mr Jordan Emery's testimony time now. Ms Morgan-Wicks and Mr Webster, you'll be staying on for the next couple of hours.

Ms MORGAN-WICKS - Yes, and our chief executives of hospitals.

CHAIR - Yes. We need to conclude your testimony, Mr Emery. I just want, before we finish, to say thank you on the behalf of the committee for coming and appearing and answering our questions today. It's really important. I can say on behalf of the committee that we understand that the work of Ambulance Tasmania and of paramedics who give themselves heart and soul every single day to protect Tasmanians and to look after them is very high quality and deeply appreciated by the committee and everyone in Tasmania. We recognise that you have increasingly come up in a very short amount of time against a hard full stop when you need to be giving patients over to the emergency department. It is really about the health system, the Department of Health's management of the hospital and how people can't get in the door, which means that you're confronted with these great pressures that people are working under today. Thank you for giving the information to the committee.

Before you go, I just need to remind you that, as I said at the beginning, your evidence was covered by parliamentary privilege and when you leave, you no longer have privilege attached to you for anything that you say, even if you said it to us here, now. Do you understand that?

Mr EMERY - I do, thanks, Dr Woodruff.

CHAIR - Thanks very much on behalf of the committee.

Mr EMERY - Thank you.\

The witness withdrew.

CHAIR - We'll just have a one-minute break while other members come to the table. Maybe a two-minute break is more realistic.

The committee suspended at 2.37 p.m.

The committee resumed at 2.40 p.m.

CHAIR - For people who have just joined the table, we have got members of the committee, Lara Alexander, Simon Wood and Anita Dow joining remotely and with me here at the table is Simon Behrakis. Welcome everybody. Thank you for attending this committee's hearings. I will make a statement before we start about the evidence that you will give today.

This is a committee of parliament, and we are conducting an inquiry. To be able to get the best evidence, this committee and what you say here is covered by parliamentary privilege. That means that what you say, you can speak with freedom and without fear of being sued or having any other court action from what you might say here today, so we can get the best possible information. It is important to understand that privilege does not pass with you as you leave the committee and that if you say something outside, even if it is the same thing that you said here today, you may not be covered by this privilege. It is a public hearing and members of the community will probably be watching online as well as journalists. Do you all understand that?

Witnesses - Yes.

Ms FIONA LIEUTIER, CHIEF EXECUTIVE, HOSPITALS NORTH, **Mr JOE McDONALD**, CHIEF EXECUTIVE, HOSPITALS SOUTH, **Mr DALE WEBSTER**, DEPUTY SECRETARY, COMMUNITY MENTAL HEALTH & WELLBEING, **Ms KATHRINE MORGAN-WICKS**, SECRETARY, **Mr BRENDAN DOCHERTY**, DEPUTY SECREETARY, HOSPITALS AND PRIMARY CARE, AND **Ms LAURA PYSZKOWSKI**, ACTING DIRECTOR, OFFICE OF THE SECRETARY, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you.

Ms MORGAN-WICKS - Madam Chair, may I give a brief opening statement?

CHAIR - Of course you can.

Ms MORGAN-WICKS - As secretary for the Department of Health I am very pleased to be able to address the Select Committee on Transfer-of-Care Delays and detail the work that we are doing to improve our health system so that it meets our needs now and into the future. The Department of Health's focus is on ensuring Tasmanians receive the right health care in the right time and at the right place. This is a significant and daily challenge that over 15 000 people work across our public health system in Tasmania to get right. We know that it is impossible to achieve in 100 per cent of all episodes of care.

I recognise that delays in transfer of care negatively impact health outcomes and patient experience and I acknowledge the terrible impact this has on families, on carers and on our staff. I firstly wish to extend my apology to those who have not received the care themselves or for their loved ones in any way if that care fell short of what they should have expected to receive from us. I have reviewed the majority of submissions and tuned in to hear a lot of the testimonies from the members of the public, representatives of our health unions and partners and our staff to this committee.

As secretary, I positively support any member of our staff providing information to the committee and acknowledge that in some cases this has revealed very challenging circumstances and outcomes, or details of delivery of care that did not meet our high standards in every instance. I acknowledge these failures and reinforce my and my department's commitment to continue to face these challenges head on and to keep pushing to improve. I thank each witness for coming forward to share their personal experiences or to provide their expertise to assist the committee.

I want to state from the outset that while transfer-of-care delay is an incredibly complex issue, and involves a range of contributing factors, many of which you have heard from witnesses to this inquiry, our department is committed to addressing each and every contributing factor or suggested solution, both inside and to the best of our ability, those outside our span of control.

No one in charge of a health system would want any patient or staff to experience these delays, and quite frankly if the solution was simple, we would have already implemented it. I receive and review patient-flow reports every day, multiple times a day, seven days a week. Access and patient flow are our highest strategic priorities for the department, and one that we continue to work hard to manage every day. I have sat in many rooms, real and virtual, with staff across the state, and spoken to many members of our community to listen and to ask for their suggested solutions, as have many senior people before me. I also directly engage with health chiefs nationally to share new initiatives or to seek their assistance for Tasmania, so that we can benchmark and improve. What usually happens is that we come up with a long list of access solutions or improvements, which staff then work to prioritise, resource, develop, and deliver.

But we know that health care is not static, and it is not perfect. We deliver complex public health services against a constantly changing background, including in the last four years facing the significant peaks of the COVID-19 global pandemic. The impacts of COVID-19 remain challenging for our health system with significant workforce impacts and now global competition for increasingly scarce health resources. As demonstrated by our department submission, our public health system works every day to manage this growing demand caused by population factors, system interface challenges and declining access to primary care - all adding up to a public hospital system that is often the provider of last resort and dealing with sometimes predictable and sometimes unpredictable surges in demand. I want to please assure everyone involved that while awaiting the important recommendations from this committee, and from the independent review of Tasmania's major hospital emergency departments, we continue to undertake this work to improve service delivery, optimise patient access and flow within our health system, and to support our health workforce.

I could go through a list of all of the initiatives that we have attempted, and that have been identified by our staff, but I will not, obviously, at this opening stage, because I know that you will have many questions. But I do want to reinforce that it remains an absolute strategic priority from our department, and I am very keen to receive the recommendations of this committee, particularly if it is going to identify something that we do not already have on our list or program, or if there is a better way or a way in which we can prioritise the lists that we have received from clinicians and non-clinicians working right across Tasmania and also nationally as we compare. I do want to thank everyone that has come forward to the committee, and we do very much appreciate and are listening, and following very closely.

CHAIR - Thank you very much for that opening statement. You made some really important comments in there. I ask whether the department has a view about the risks that are associated for patients with ambulance ramping. What is your understanding of the extra risks associated for patients with ambulance ramping?

Ms MORGAN-WICKS - Dr Woodruff, the department's position, and one which we share very publicly and also with our staff, is that there are significant risks associated with transfer of care. I think I sit here as a secretary and I would be in agreement with every secretary and chief executive of the health system in Australia, if not globally, to accept that there is significant risk, which is why access and patient flow is one of our key strategic priorities to improve at the department. We would not invest such significant resource if we didn't believe it was one of the significant risks.

CHAIR - To be clear for the committee, you accept that there is an increased risk of harm or adverse events the longer that a person remains on a ramp and is not admitted into the emergency department and thence into a bed as required?

Ms MORGAN-WICKS - Yes, as secretary I accept that.

CHAIR - We've certainly heard from doctors, nurses and, obviously, paramedics who do their absolute best every day that the scope of practice of paramedics and the protocol issues mean that patients can't receive the important medications and treatments, and often pain relief they need while they're ramped and that they can't receive certain diagnostics while they're ramped. Do you accept that that's true?

Ms MORGAN-WICKS - To the extent that I am aware, patients do receive, or diagnostics and treatments can actually occur whilst a patient is within our transfer-of-care areas within our hospitals. Trying to discern in terms of the word 'ramp', I note the concern in the community that we are making a ramp, that they think patients are being held, for example, in the back of an ambulance and being treated outside of the hospital, whilst they are actually transferred into a hospital service. Some diagnostics may commence, some pain management may commence, and treatment may commence but without a formal transfer of care actually occurring for those that are delayed.

CHAIR - But do you accept that the paramedics are not able to provide that treatment, that additional pain relief outside their scope of practice or those diagnostics themselves while they caring for a patient on the ramp?

Ms MORGAN-WICKS - If it is a general statement, yes, I accept. But I am aware, and I can have one of our clinicians speak to the commencement of care, the types of treatment that can be provided, for example, by a paramedic but there are obviously limitations. I absolutely accept limitations in the scope of practice of paramedics who are unable to perform various diagnostics or treatment courses until the patient is reviewed and assessed by a clinician within the emergency department.

CHAIR - When a patient is on the ramp in the care of a paramedic, being reviewed and assessed means being taken off the ramp and handed over to the care of an emergency department clinician or nurse?

Ms MORGAN-WICKS - Yes. Dr Woodruff, I am not trying to be difficult on this. It is just that I am also aware because I have had paramedics tell me about taking patients, for example for X-ray or CT, for diagnostics to commence whilst still remaining within the care of a paramedic, which is not our recommended practice. Our recommended practice is to try and meet our targets for transfer of care through to the treatment of our emergency department personnel.

CHAIR - The evidence from around Australia and from around world, from international research, shows a clear link between a patient being ramped and their health outcomes. The evidence from Victoria shows that a patient ramped for 17 minutes has an increased risk of death or negative outcomes in the following 30 days. Do you accept that evidence?

Ms MORGAN-WICKS - I am not aware of the particular 17-minute data you refer to, but I accept the tenet of the concern that there is an increased risk associated with transfer-of-care delays. We absolutely accept that, which is why it is a priority for the department to try and improve and reduce transfer-of-care delays in our hospitals.

CHAIR - For every increasing length of time on the ramp, there is an increasing risk of an adverse health outcome occurring. It is related to the length of time.

Ms MORGAN-WICKS - I might refer to my deputy secretary for hospitals.

CHAIR - This is quite commonly quoted research. It's been provided to us on the committee by many different people. Different research here in Victoria but also overseas research is quite conclusive. We've had numerous people provide this to us.

Ms MORGAN-WICKS - Which I accept.

CHAIR - Great, you accept it. The weight of evidence from the committee, the relevant protocols we've reviewed, and the scientific medical evidence show that access block leads to increased harm. What this means in practice is that patients who are in the emergency department itself are more likely to have better outcomes when compared to a situation where those same patients would be on the ramp. Do you accept that there are divergent outcomes occurring within the Tasmanian health system for people in a similar state of emergency or health risk?

Ms MORGAN-WICKS - I accept it. But I also do not want to forget the patients waiting in our waiting rooms who may be assigned a similar triage category, which can be from one through to five, in terms of comparing a patient that is waiting often in a more stable condition with a paramedic attending, compared to, at times, significantly high triage-score patients walking into our hospitals. I have to accept the risks across our waiting rooms as well.

CHAIR - Sure, but when a person goes to a waiting room in the emergency department, they can be seen by a clinical doctor who can provide them with medical treatment and diagnostics that a person couldn't receive if they were on the ramp.

Ms MORGAN-WICKS - I am happy for Brendan, as deputy secretary, to walk through that they will not necessarily see a clinical doctor as they walk into our emergency department.

CHAIR - No, but if they were an equivalent category level, they could be in the care of a clinical doctor who can provide them treatment. But if they are on the ramp, they are waiting to have care and they can't receive the similar standard of care from a paramedic because it would be outside their scope of practice.

Ms MORGAN-WICKS - I might ask Brendan to walk through the way in which we triage our waiting-in patients compared to patients that are waiting in our transfer-of-care delay areas with paramedics, because they are assessed into one triage system. Doctors within the emergency department are making decisions as to whether they see, for example, a triaged category 4 patient sitting with a paramedic versus a triaged category 4 patient sitting in our waiting room.

CHAIR - It's not the triaging that I am concerned about. It is the ability to get a particular treatment if they are on the same triage level. What we have in the community is a reasonable expectation that if they call an ambulance, it means they will be able to get appropriate care faster. If a person has heart attack symptoms or they think they are having a stroke, they would think they'd be able to get care faster if they ring 000 and get an ambulance. But what we're finding and what we are hearing is that those patients can be ramped, and it can be the opposite. They can be on the ramp, as paramedics have told us, for hours and hours and not be able to receive any additional care in that space because the paramedic does not have the scope of practice to provide it.

What we're concerned to find out is that it doesn't appear that the department has undertaken the work to understand the specific impacts that ambulance ramping is having for patients. We haven't yet heard the evidence of the understanding of the specific impact. You've accepted that there is a greater impact or a greater risk for people on the ambulance ramp, but we haven't seen the evidence of that. Maybe Mr Docherty would like to provide some evidence to us.

Mr DOCHERTY - I have been in both the Royal and the LGH emergency departments recently, at the elbow if you like, and working with our clinicians, talking to patients, and experiencing what it's like to have a transfer-of-care delay. I think we need to be mindful that quite often when a community think of being on the ramp, they think they are actually sitting in the back of an ambulance in a car park. But actually, these patients are sitting in a corridor inside the doors with the ambulance paramedical crew, who are obviously professionals under the code of practice, and usually nurses and doctors are circulating in that area. At any time when a patient is experiencing a transfer-of-care delay, and they may be a triage 3 or triage 4, at any point they actually deteriorate, the paramedic crew are able to locate a nurse and doctor locally to then reassess that patient service required. It doesn't mean there's a physical space within the main emergency department to look after that patient until that reassessment takes place.

But the secretary is quite correct. We do have people who are local who actually drive to emergency departments who may be a high triage category, come in with chest pain, who need immediate venipuncture, ECG and chest pain management. They would be prioritised over somebody with a lower triage score in the transfer-of-care area waiting for a bed.

CHAIR - Thank you. We've been trying to get some evidence in this space to make some recommendations and we've heard from many paramedics who have talked about patients declining because they've been on the ramp for so long. If they had, under normal

circumstances, been taken directly into the emergency department and admitted, they could have had the treatment and they could have had the timely diagnostics they needed to prevent their deterioration. To be able to get some information and insight, we asked the department about the number of patients that died while ramped in a five-year period. The response from the department was that no patients have died in that five-year period. However, we know from the coroner that a woman died while she was ramped at the LGH during that time and another woman died in the ramp area at the Royal Hobart Hospital. How do you explain that discrepancy?

Ms MORGAN-WICKS - I think the department has provided information in response to a question that identified the number of patients who have died within 24 hours of emergency department hospital admission after being subjected to a transfer-of-care delay.

CHAIR - That's the second question. We also asked about the number of patients who died on the ramp and were told no patients had died on the ramp.

Ms MORGAN-WICKS - I think we've also identified that we don't have data that indicates that location according to the deaths because those deaths were later then recorded as proceeding into the emergency department.

CHAIR - Why is that, when there's evidence from the coroner that the patient died on the ramp? And why is it, when there's evidence from the paramedics who were present, and the family members of another woman who died in a ramp in a separate room? It was called the Emu A, but it was still part of the ramp. Why doesn't the department's data capture those as deaths on the ramp?

Ms MORGAN-WICKS - We have noted that feedback from the committee and in relation to questions that have been asked. We are also working very hard in terms of our system upgrades that we are attempting. It is a 10-year journey for the department to develop systems that are actually going to record, and we talk to our staff about what are the requirements for these systems, where do we need to improve. If it is about identifying or tracking, for example, via a code or other tracking device as a patient moves from ambulance through to our transfer-of-care delay areas within the hospital, through to emergency department, to diagnostics, and back again, sometimes back again to the waiting room, for example.

We've also got our protocol. We've spoken about the transfer of care from our paramedics through to waiting room for more minor cases, but obviously that's not the case with these higher-acuity cases identified by the coroner. We take that feedback and we're happy to feed that into the data systems we are developing and working on as we speak.

CHAIR - Well, this is not news to you or the department because this is something that's been raised in the Estimates process for years now. I and probably other members on the committee have been asking questions of Mr Webster and yourself about code blues, about the data that's been collected, about the reports we have been getting, increasingly concerned reports from paramedics about the number of people who are suffering adverse events on the ramp, and those not being captured by hospital data.

Here we have a situation, years down the track, where it sounds like you, for the first time, have just discovered that there needs to be more information. We don't understand, when

we ask the specific question about how many deaths on the ramp, how we could get no deaths. What happened to the recording of those deaths that they are not recorded as a person dying on the ramp when the evidence is there from the paramedics that the person died on the ramp? Why is that not recorded?

Ms MORGAN-WICKS - The death itself is recorded. I absolutely want to make clear, particularly for members of the public that are watching. The death is recorded as a death that is occurring within the Royal Hobart Hospital or the Launceston General Hospital, or that location. Where our systems are currently failing us is to pinpoint specific locations and categorising the data right down to the physical location of where that death actually occurred. These corridors are corridors within large-scale emergency departments -

CHAIR - But they are known to be part of the ramp. They are a place where paramedics are responsible for patient care, where they have not been handed over. Whether they're in a broom cupboard, a linen closet, the corridor, the back of the ambulance or in the airlock, they are all part of a ramp because a paramedic is responsible for the patient, and they have not been handed over. Clinical staff at the hospital have not taken responsibility for that patient and, on at least two occasions, patients have died, but have not been recorded as having died on the ramp.

Ms MORGAN-WICKS - Dr Woodruff, I'm not attempting to dispute that fact and certainly do not question coronial findings. What I am talking about is the improvements that we need to make to our systems. I haven't suggested that this is a surprise to me. What does take time is the improvement of large-scale hospital systems, which we are working on through our Digital Health Transformation project. These are costing hundreds of millions of dollars to get right and to get into our system. We're taking feedback from all of our clinicians about what they need so that we can make sure they are able to do their jobs for safety and serious safety events, such as a death occurring within a corridor.

I can come back to the concern raised in relation to a broom cupboard or a linen closet and happy for each of the chiefs to talk about those particular areas that have been referred to in testimony.

We will do all that we can to try and improve the data, but it requires the systems within the hospitals to be able to capture that. That's why we've achieved and we're very vocal about, together with the AMA's support, to achieve a $476 million investment in digital health in Tasmania.

CHAIR - But what's resulted for this committee is that we've got false information from the Department of the Health about the reality of at least two people who died on the ramp. What we're trying to get here is an understanding of the severity of risk, the extra risk for patients who are on the ramp. You've already acknowledged that there's an increased risk, but we still can't get to the bottom of how serious it is because you're saying your systems don't even record the fact that where that patient died, they were obviously on the ramp. I don't understand what technicality happened that it could possibly be recorded as not having been a ramped patient. Was it because at 11:59 a person declined and needed resuscitation and then was handed over to a person who attempted to give resuscitation and they died a minute later, and that was recorded as a death not on the ramp?

Ms MORGAN-WICKS - It is recorded by our clinicians in the existing systems that they've got to record.

CHAIR - That sounds incredibly problematic because it clearly is not, in any way, giving Tasmanians information about what's happening to people who are on the ramp.

Ms MORGAN-WICKS - But all serious safety events, including deaths of that nature within a hospital, are also referred through to the coroner. In terms of our own safety and reporting systems, it would be the subject of significant root-cause analysis, and information and recommendations flowing back through to both treating clinicians, to the emergency department itself and Ambulance Tasmania, and through to the executive of the Department of Health. Mr Webster might have some further detail if that assists you, Dr Woodruff.

CHAIR - Do you think that it's fair to say that the department is not able to provide us with any information about the adverse outcomes or the number of deaths that are occurring to people who are ramped in Tasmanian hospitals?

Ms MORGAN-WICKS - The department has provided information in relation to deaths within our emergency department and also deaths of admitted patients and I note -

CHAIR - Not on the ramp?

Ms MORGAN-WICKS - I note the concern raised in relation to being unable to provide that information because we haven't recorded that location data within the system.

CHAIR - But it's false information. I need to correct that because it's not deliberately -

Ms MORGAN-WICKS - That's a serious allegation, Dr Woodruff, which I have not attempted to provide false information on behalf of the department to the committee. I'm reflecting the adequacy of our current systems, our effort to try and improve them and we absolutely note the feedback from committee about wanting that particular data source within our systems, which we can include.

CHAIR - I will rephrase that. It's incorrect information that the department has provided because the department said that no deaths had occurred on the ramp. We know that at least two deaths occurred on the ramp and that means that the department is not able to provide correct information to Tasmanians about how many people are dying or having adverse outcomes on the ramp.

Ms MORGAN-WICKS - Dr Woodruff, I'm happy to check our response -

CHAIR - Do you agree that that is a fair statement?

Ms MORGAN-WICKS - Because I believe that our response qualified to state that we do not record that location and we're unable to provide that data with that location source. If we haven't, I'm happy to provide an accurate response to the committee which is always our intention.

CHAIR - Okay, but as it stands, that information - you don't collect it, or if you collect it, it's mis-noted, that the information that you have is incorrect because it doesn't provide you

with precise information about whose care a person was under and where they died within the hospital.

Ms MORGAN-WICKS - But Dr Woodruff, putting aside our limitation in the data, which we have acknowledged and we'll seek to improve, we also have the reporting of serious safety events by paramedics, by our own emergency department staff who often move in to treat a deteriorating patient and taking them through to a resuscitation bay, which is off-corridor and into our emergency department and where the treating clinician then records the location of death. If I may ask Mr Webster -

CHAIR - If you had something extra to add to that, or is what we've said incorrect?

Mr WEBSTER - I think it's important. I spoke earlier about veracity of data, and we have to record within data systems and that is done by clinical coders sometimes sometime after an event occurs. But within our safety system we are recording precisely where it is and the coroner has found out where it occurred from the report that we put through. It's just extracting that data when it might be in a free format within the safety system, it is getting the information out.

In terms of the actual data we can extract, it comes from a series of fields which would record generally where in the hospital it occurred, but the free format safety report would give us precisely where it is, but it's almost impossible for us to extract that, which is why I talked earlier about making sure we had veracity of data. The secretary spoke about - and we'll identify the government agreed to fund this - that we need better electronic medical records so that we can get to this level of data and understand it at the level that you're now talking about. It is around where it's recorded in the system, so we know about it at that one individual level. We report that to coroner, through our RCAs (Root Cause Analysis) and our open disclosure processes but extracting that data from free format to try to work out where exactly it was is the problem we have.

CHAIR - Why didn't you provide that data to the committee when we asked for it? You could provide it to a coroner, but you couldn't provide it to the committee?

Mr WEBSTER - I'm not saying we provided data. We provide a report to the coroner and that is the difference; that extracting data that vaguely says it's in the ED and you wanted specificity about ramp, well, we would have to go through individually, manually, to get that data, because it's a manual process of the safety report, which the paramedics will fill out, which the ED nurse might fill out, the ED doctor might fill out, which then flows through to the coroner. What I am talking about is the individual information that we absolutely have versus a data system that can collect that from that individual record up into meaningful data. That's why we need to replace our digital system so we can get the level of specificity that you are wanting in this inquiry.

CHAIR - Given what we have talked about and given what we have understood through this inquiry are the urgent and increasing risk for people who are on a ramp, do you agree it is an urgent priority for the department to have this data collected and make it available so that we can understand what the impact of the increasing length of time is having on patient out outcomes?

Ms MORGAN-WICKS - We do agree, Dr Woodruff, if I may respond as secretary for the department. We do agree, in terms of the importance of collecting that data, which is why we will include that in the next upgrade and iteration of the systems. It is a significant piece.

CHAIR - When would that happen? It sounds like years away.

Ms MORGAN-WICKS - We can ask the questions in terms of enhancements to the system, but I also note, and want to make very clear, that no death is missed, for example, within our emergency departments. We also monitor rates of mortality across each of our services. We benchmark those rates of mortality against other similar interjurisdictional comparisons. For example, the death rate in Tasmanian emergency departments in 2022-23 was 69 deaths per 100 000 patients, which is similar to the national rate of 70 deaths per 100 000 patients.

CHAIR - Thank you for that statement earlier about the importance of gathering that data. We certainly have heard many people think it is a baseline piece of information that we have to have to make responses to that. Ms Dow you have been patiently waiting. You've got some questions?

Ms DOW - Thank you for presenting to our committee this afternoon. I want to ask you about the patients who are caught up in all of this and their families and whether their families are notified of the situations that surround their death. For example, if a patient dies on the ramp, if a family member is not present with them, are they informed of that? Are they informed if there is a referral made to the coroner to review the case?

Ms MORGAN-WICKS - I might go to one of one of my chief executives of hospitals to reflect on experience in reality. I can describe generally the process of our recording of a safety event within our hospitals; the work and investigation that we do into those safety events often involving independent clinical expertise to determine recourse analysis and then the recommendations to improve that flow from that - but importantly the process of open disclosure with every family. Because whilst we are talking about deaths, every single death is a tragedy that dramatically impacts; on families, their carers and the community that surrounds them, which is why this is such a significant priority for all of us. I will go to Fiona Lieutier, our chief executive of the Launceston General Hospital.

Ms LIEUTIER - Thank you, Ms Dow. We certainly undertake a process of open disclosure with the families of people who die within our emergency department undertaking a transfer-of-care delay. That process involves contacting their next of kin by the hospital. We then coordinate with the family to hold an open disclosure process where we go through everything that occurred that may have contributed or led to that death. It is also recorded in our safety system. We undertake a number of inquiries including a root cause analysis and that is quite detailed and that is usually provided to both the family during the open disclosure process, which may be more than one meeting. It may be a series of meetings and in some cases, even myself as chief executive, will maintain contact with the key family members until such time that they feel comfortable to no longer have contact and they feel their matters have been resolved.

Hopefully that answers your question, but we are very careful about ensuring that we are transparent with the families of people who do pass away in our care and custody.

Ms DOW - If patients are on the ramp for an extended period of time and they don't have a next of kin with them, which I understand through experiences shared through this committee, next of kin haven't been notified that their loved one was seriously unwell and ramped, at what point in time would you notify the next of kin that the patient's current clinical status was really critical rather than them dying alone on the ramp?

Ms LIEUTIER - Our aim would be to never have anybody die alone on the ramp or during a transfer-of-care delay. It would depend on the individual circumstances in relation to how and when family members are contacted and sometimes we have difficulty in understanding who the appropriate or correct next of kin is and we do have to be mindful of ensuring that we are notifying the right people at the right time. We would never want people to be alone in our hospital receiving care where their life is certainly at significant risk. Usually, it would be between either the hospital, the triage nurse, the nurse in charge or the paramedic who would contact the family if they were undergoing a transfer-of-care delay.

Ms DOW - We are aware of the situation through this committee, hearing that it did happen, and that person did die alone and the next of kin weren't notified. You would be aware of that through reviews that have been undertaken since that time. Can you provide to the committee an update or any protocol or procedure that has been put in place to ensure that it doesn't happen again?

Ms LIEUTIER - I would have to take a minute to refer to my notes but I know that certainly in relation to the coronial and matters that I am aware of, we have implemented all the recommendations from our root cause analysis and the coronial investigations that have been undertaken to ensure that families are kept abreast of our patients' care and the outcomes. It is certainly something that we would never want to happen, and I do acknowledge it has happened in the past. I can certainly reflect on my notes and come back to you shortly in relation to particular instances, but we certainly have implemented all policies in relation to the coronial matters that I am aware of that have been undertaken, particularly at the Launceston General Hospital.

Ms DOW - Thank you. The last question that I have is in relation to people as well. It is in relation to our staff and the conditions that they are subjected to, particularly what we have heard through this committee, working in emergency departments. We have witnessed that firsthand, as we have done a tour of the Launceston General Hospital Emergency Department. You refer to the fact about where people are ramped and whether that is in corridors and in cupboards, which isn't ideal. The Health Department has been aware of the issues with ramping and the lack of space in our emergency departments now for years and what was coming with our ageing population and high levels of chronic disease. Why are we still subjecting our staff - which we have heard from during the last hearings, who are absolutely broken - to these working conditions. When you're subjecting them to those conditions day in and day out, how can you expect them to keep turning up each day?

Ms LIEUTIER - First thing, Ms Dow, our staff are absolutely outstanding, and I completely acknowledge that they do a wonderful job 24/7, 365 days of the year, and a lot of staff come to work in many service organisations because they want to make a difference to the community and our staff are absolutely no different. We try to provide the best facilities that we can, and this evidenced by the master planning that's particularly been undertaken at the Launceston General Hospital, where our facilities are going to be improved. There are cranes at the LGH right as we speak. Air conditioning has been improved, so we are completely

focused on trying to make our facilities the best we can for both our patients and our staff, and also the families that come to visit them. I am sorry, I probably lost track of your question a bit there.

Ms MORGAN-WICKS - If I can add, Ms Dow, your question is not Launceston General Hospital specific, because I note that that is the experience across all of our hospitals, and our continuing consultation with staff, both within Ambulance Tasmanian in terms of the facilities and infrastructure that they have to work to their full scope of practice within, but also our emergency department staff. At the LGH, for example, that is why we had the focus on the improvements within the ambulance airlock, certainly noting a lot of feedback from patients, but also from Ambulance Tasmania personnel as to the comfort levels within that area.

A significant amount of work went into that airlock, and also into the transfer-of-care areas within the LGH. I note that you have toured those areas. You have seen some of the areas, for example, the second corridor within the LGH in which patients may end and which we know is not satisfactory and we need to do further work in terms of that infrastructure to improve it. But it is not a cupboard, it's not a cupboard with doors, and certainly Fiona can speak to the space, and I have stood in the space, as our paramedics and emergency staff have.

I note I also have similar conversations with ED staff saying, 'Do not focus on increasing the size of our emergency department, focus on additional beds within hospitals, focus on sub-acute beds out in communities so that we can move patients out to improve the flow.'

I note that we are up to 3:30 p.m., we have not yet moved beyond the ambulance or the ED, to the significant problem that is actually facing us, and that is the timely flow of patients through our admitted wards and the interface with aged care and NDIS and the long stays within hospital that are impacting our length of stay. We have delivered some significant infrastructure improvements, particularly at the Royal, with some 28 treatment points of care that have been opened over the last two years - which I know that you have also probably received a tour of - in trying to supersize and increase the capacity of our emergency department to make it a better place to work in for our amazing staff who are doing an incredible job in very trying circumstances.

Ms DOW - On more thing on that, before I hand back to you, Chair. You have mentioned about capital infrastructure, but say, for example, at the Launceston General Hospital there is a 10-year master plan and $580 million that is being committed to that project by the government, yet we have seen very little money flow in the state budget to that project. The fact is that it takes time to build buildings, so there must be some interim solutions, and I just want to understand what other opportunities you have identified for more sub-acute beds to be made available in the community so that we can transition those patients out into the community, and that their care would be much better provided for in that setting.

Ms MORGAN-WICKS - For example, at the Launceston General Hospital, our focus, particularly through the COVID-19 pandemic, was to open as many beds within that environment that we safely could, noting that beds physically can be opened, but you also need to maintain the safe staffing around those beds to physically operate them. Certainly, as of 31 December 2023, 232 additional beds have been opened state-wide, and with 36 of those under our public-private partnership. We not only look within the space within our own existing infrastructure but try to push as far as we can our private partnerships to safely open beds. That is probably where we get to that sub-acute criticality, and particularly as we can

provide then that step-down care, for example, through partnerships with Calvary St. John's here, for example, in the south, to seek to increase the number of beds available to improve flow, which then impacts back onto the emergency department, then back onto our paramedics experiencing transfer-of-care delay.

CHAIR - The committee asked for some information about the number of patients who died within 24 hours of being ramped for 30 minutes or more in hospitals in Tasmania. The information we received was that in the last five years of reporting period, 136 people had died within that 24-hour window, 16 deaths in 2018-19 building up to 44 deaths in the last year of reporting. As I mentioned earlier, a recent Victorian study showed that ramping of just 17 minutes or longer was linked to worse outcomes for patient in the following month. We were talking about deaths a day after an extended period of ramping. To be clear, I'm not commenting on an individual case but we're talking about population-level impacts. We see that a steep increase in ramping length has led to a dramatic increase in deaths the following day after an extended ramping period. Do you accept there is an impact on patient mortality at the population level from the extended ramping we're seeing?

Ms MORGAN-WICKS - Yes, I do accept that, which is why this is such a significant priority for everyone who works within Health.

CHAIR - That's good to hear because there was a minister who seemed to think that was an unreasonable relationship to draw from that data.

Ms MORGAN-WICKS - I think there are many comments that can be made about trying to link cause or contribution, or the level of chronic disease that exists within the Tasmanian population, the ageing population we have within Tasmania. But also, the significant increase in demand we've experienced over the last three to four years, not so much in ED presentation, which has remained relatively static, but the acuity of the presentation to our hospitals has increased. We have, though, seen an increase in presentation by Ambulance Tasmania, calls to Ambulance Tasmania. That is all impacting against that background and our attempts to try and implement improvements to address transfer-of-care delay, whether it's hospital avoidance initiatives such as our COVID@homeplus program, our mental health emergency response, or PACER, program, our secondary triage program within Ambulance Tasmania to try and make sure that the lower acuity cases are not all requiring an ambulance presentation, for example.

If we look back some four years ago, to every single call to Ambulance Tasmania we sent an ambulance, is my understanding. Programs like secondary triage, which we picked up directly from Victoria and, in fact, had resources from Victoria to help us implement in Tasmania, have been a fantastic success.

CHAIR - Hospital in the Home as well.

Ms MORGAN-WICKS - We are certainly not a Health department that sits here, that does not care and is not trying. Every initiative suggested to us by our many clinicians right across the state, they are making little bits of impact. It's really hard for me as secretary to say, 'Right, I can show you the minutes we shave off', or the impact each of those initiatives individually have. They're integrated, it's a very complex network of events. But I also have this significant uplift in demand. As we try to make improvements, we're also experiencing that demand, which is caused by those factors of ageing population, significant chronic disease

across Tasmania, a deterioration in primary care provided to Tasmanians and, again, the hospital and the public hospital, or the call to triple-0, being seen as a method of last resort for people to actually achieve health care. When people are unable to see their general practitioner, their acuity increases. We know that. And then the higher acuity cases are hitting our EDs.

CHAIR - Do you agree with the evidence of - I'm thinking here of a number of staff from the Emergency Department at the Royal Hobart Hospital, and also from paramedics, from the senior clinical staff at the emergency department at the Royal Hobart Hospital, the Australian College of Emergency Medicine - that it is not the people who have not been able to access a GP that are causing an increasing problem on the ramp. Those people would never need an inpatient bed. They are people that, for example, the Royal Hobart Hospital regularly deals with. As we heard, 45 000 people walk in to get services that do not require a bed, who are never going to need to go into the hospital. Then there are 23 000 extra people who are short-stay and there are 10 000 people that need to go and have a bed in the hospital. The narrative or misunderstanding that it's people who ought to be going to a GP that are clogging up emergency department beds is a misrepresentation of what you have just referred to - the true increase in the number of people who need serious care who are going by ambulance but are unable to get a bed because of a range of bed-block issues in the hospitals.

Ms MORGAN-WICKS - I'm certainly not suggesting that patients that are waiting to be admitted while sitting in beds or lying in beds in our emergency department are not an issue which we are absolutely focused on. That is why we have flow initiatives focused on discharge, criterion-led discharge, sub-acute transfers, working with aged care and NDIS, for example, to increase the flow of admitted patients through our hospitals. But it is accurate to say that some 40 per cent of presentations, so within our lower acuity, could potentially be dealt with by a GP or pharmacist. They will come into a treatment and point-of-care space within our emergency department and take the time of a clinician, particularly where they are unable to access any other form of care. So, I'm not trying to misrepresent -

CHAIR - But none of those people are people who would need a bed in the hospital, and they are not being any part of the bed-block issue in the hospital for people on the ramp who genuinely need to have a hospital bed and who can't receive one. That's got nothing to do with those people who walk in?

Ms MORGAN-WICKS - But noting, Dr Woodruff, that there are triage four and five on the ramp as well, the same as in our waiting room. It is not just our one, twos and threes that are brought in by ambulance. They will bring in if there is no other transport option available for some patients or they can't get them to a pharmacist or a GP within the community.

CHAIR - Clearly there is real need in the community to have access to a hospital and have transport for people in regional areas. We've heard there is absolutely no other way for them to get there. And many people genuinely don't understand whether it is an emergency or not. It's only by going to a hospital and being triaged that they can understand that it is a higher order emergency or that -

Ms MORGAN-WICKS - Or through secondary triage from our paramedics.

CHAIR - That's right. I suppose people in the community would expect that the ramp wouldn't be clogged up with people who don't need to have a bed; they should just be organised,

triaged, and dispatched from that space immediately so that paramedics are freed up to go back onto the road.

Ms MORGAN-WICKS - And that is what our protocols and our processes are designed to achieve.

CHAIR - That's a new thing that you've just announced?

Ms MORGAN-WICKS - We've had several protocols for a long period of time. Mr Emery, for example, spoke about our inter-hospital protocol where, for example, a patient from the north-west who has been thoroughly reviewed and assessed by clinicians within the North West Emergency Department is then transferred to the emergency department of the LGH to receive the same assessment again or similar diagnostic tests. This is why we introduced the inter-hospital transfer protocol to remove that second form of triage at another emergency department to try and achieve direct admission to a clinician within the LGH, avoiding the ED.

CHAIR - From what you're saying, you've already got protocols in place to deal with the triage four and five categories, so that's not a problem on the ramp?

Ms MORGAN-WICKS - I'm not suggesting four and five are not a problem on the ramp. What I am saying is that there are four and five patients that are treated with the same level of priority whether they're brought in by an ambulance or whether they're walking into the waiting room. I've stood in triage for several hours at the Royal and also at the LGH to watch exactly what is happening, to try and understand and see the systems they are using, the judgements they're making, the single lists; once a paramedic, for example, brings in a potential triage four or five, which is the assessment of the triage clerk, how that then is compared against other fours and fives they've triaged in the waiting room. Waiting room fours and fives may go in before a four or five held by a paramedic that has been stabilised by a paramedic. I've seen it actually happen within our system.

CHAIR - Clearly, this is a problem. One thing is the transport of people to the hospital but a much more serious issue that we're hearing is paramedics being stuck on the ramp when they should be out in the community answering triple-0 calls. That's what they're trained to do, that's what they want to do. You're saying the department has now got a protocol in place to deal with the fours and fives on the ramp?

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 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.

Ms DOW - My next question relates to the availability of 24-hour pathology services, radiology services, pharmacy services across our major hospitals. I think there are some changes afoot at the Royal around medical rostering 24 hours. But, 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 MORGAN-WICKS - I might ask Fiona to comment first in relation to the LGH and the existing 15-minute on-call arrangements.

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.

Ms MORGAN-WICKS - I might ask, Ms Dow, if Mr McDonald can comment from the perspective of the Royal.

Mr McDONALD - Yes, it is a similar issue. 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 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.

Ms MORGAN-WICKS - If I might add, we do, though, receive feedback and requests in relation to increasing our diagnostic infrastructure across the hospital. There's the issue of the 24/7 availability versus an on-call and call-back arrangement but also the utilisation of existing diagnostic infrastructure within our hospitals. For example, we are very much focused on our angio suites and the volume that is going through some of our diagnostic infrastructure within each of the regions. That's why you'll see from the master planning processes where we've highlighted, brought forward or prioritised replacement or additional infrastructure. For example, the second angio suite at the Royal Hobart Hospital is one of those projects.

Mr WEBSTER - If I may add, Ms Lieutier mentioned about the statewide review of pathology, and I think that's really important. 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 - The review is underway and the time line put on that is 12 months. 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 time line on that project is 12 months.

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?

Ms MORGAN-WICKS - Sorry if we are looking quizzically at each other because I speak to very keen nurse practitioner students and certainly in relation to their location and utilisation within the Tasmanian Health Service

Ms DOW - To clarify that then, the feedback that I've received is in relation to candidacy placements for people across the health system, that there is really no formal structure around that or no strategy to increase the nurse practitioner workforce across Tasmania.

Ms MORGAN-WICKS - Perhaps Mr Webster would like to start, but I note that Mr Docherty also has some comments.

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 has obviously been discussion during this committee's focus around nurse practitioners working collaboratively with general practice. There have also been suggestions made around nurse practitioners being employed, for example, at community health centres across Tasmania or other state-run facilities to complement the work of general practice but also to fill gaps where general practice isn't immediately available in community or there are shortages or workforce concerns. 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 - Before Brendan comments, 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 and I think, for example, of the nursing support that's being provided in Ouse by the Royal Hobart Hospital team, our amazing COMRRS (Community Rapid Response Service) teams that work together with general practitioners to keep patients' care within their homes and supported and noting the candidate role for nurse practitioners being our grade 6es. Whilst not a replacement workforce for GPs, what we have been trying to do through different programs of work, is to highlight their role and have them work in partnership with GPs, potentially physically in the location or virtually. We have also seen that through our COVID@homeplus program, but perhaps if Brendan would like to comment further.

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 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. The chief executives and I have had the privilege of being at the nursing midwifery workforce planning workshop on Friday and there was a resounding vote of let's get far more specific nurse practitioners and graduate nurse practitioners in the areas where we need them. 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.

Ms MORGAN-WICKS - My understanding is that, for example, the New Norfolk model of care is centred around our nurse practitioners.

Ms DOW - One last question, if I could, is whether there are discharge planners in each ward or department of the hospitals as a way of trying to address patient flow issues as well. If there aren't, why aren't there?

Mr DOCHERTY - Thanks, Ms Dow, I might start, and I might hand it to one of my chief executive colleagues. We do have discharge planners on a lot of different levels across our whole system. That goes from ward-based all the way up to facility-based to our integrated operation centres, as well as having discharge as one of our focuses on the ED review interim recommendations. We do have key positions, especially in the chronic disease group for whom it is more complex to discharge, but one of our key focuses is discharge is everyone's responsibility in the team, not only the discharge nurses, because we do not want to say somebody is being discharged so only the discharge nurse can do that. From the point of admission, every single member of the multidisciplinary team should be planning for that discharge to be safe.

But yes, we do have specific, specialised resources, because discharging or transferring somebody back to a residential aged care facility, to NDIS, or to sub-acute, does come with other complexities to navigate, and therefore our discharge planners and complex care planners can navigate that easier than your everyday person on the ward. But most of our discharges, at least 85 per cent, are being managed by the ward teams with the support of a ward discharge person.

Mrs ALEXANDER - Thank you, Chair. My question is for the secretary, but I am very happy to have an answer from whom you deem more appropriate. You have got a structure at the moment where the first 15 minutes from arrival at an emergency department is treated as routine transfer of care and then you start capturing anything above 15 minutes as delay. However, my question is whether if someone happens to be in that 15-minute window and they have an event and have to be transferred to a resuscitation area or other parts of the ED and subsequently die, how would you approach that? Would that be considered an admission, or would that never be recorded as a transfer delay? Where would that recording sit, as a transfer delay or a non-admission, or -

Ms MORGAN-WICKS - Ms Alexander, I believe that is also the root of the Chair's questions in relation to pinpointing the location of a death within the emergency department. But noting that within the first 15 minutes they are absolutely triaged according to acuity. Often, we have, for example, deteriorating patients who are within transport, so on the way to the hospital with communication to the hospital to expect to receive them immediately into resuscitation, for example, if that is not also already occurring from within the home into the transport or into the hospital. I am not trying to be answering in an obtuse way, but the 15 minutes is from a national RoGS (Report on Government Services) data collection, and often, most other jurisdictions are recording at 30 minutes. We are suggesting that we record at both the 15 minutes and the 30 minutes, and make sure that we remain consistent. Obviously, we are absolutely focused on achieving the 15 minutes but also looking at our benchmarking nationally. In terms of a deteriorating patient, whether it is within 30 seconds of arrival at the hospital, or three minutes or 15 or 20, having that ability of the paramedic treating team to immediately escalate to then have treatment, whether it is within a resuscitation bay or otherwise within the emergency department. Mr Webster?

Mr WEBSTER - And just to comment on the recording of it, up until very recently, when the ambulance arrived at the hospital was a manual step, so paramedics focused on treatment of the patient had to actually record, 'I have arrived at the hospital', and the start time was variable. The government's rolled out and emergency services have rolled out TasGRN - and I don't know what the acronym stands for, the Government Radio Network, that's it - but that now allows us to track the ambulance, so we know what time it's arrived. It's become an

automated process now for Ambulance Tasmania to say that ambulance is in the vicinity of the hospital. Start the clock going.

Ms MORGAN-WICKS - And certainly when I referred to the 15 minutes versus the 30 minutes, I reflect on our colleagues at ACEM, so the College for Emergency Medicine and their recommendation around recording the 30-minute. So, we're trying to achieve 100 per cent by the 30-minute target.

Mrs ALEXANDER - Basically, just to clarify this and I may be wrong, the data that we have in front of us is the data that you start collecting after the 15 minutes and not prior to that window from arrival to 15 minutes? So, basically what I'm saying is the ambulance has arrived, its clock is time zero, and then you've got 15 minutes. So, the information within those 15 minutes is not reflected in the data that we have in front of us. Is that correct?

Ms MORGAN-WICKS - Sorry, Ms Alexander, I'm just seeing if either Laura or Brendan can comment because we're certainly aware of and able to report on achieving or not the 15 minutes, so we don't just start a clock at 15 minutes if that is the question?

Mrs ALEXANDER - Yes. I'm just trying kind of get a feel about the accuracy of the data, because obviously to compare apples with apples and especially over the years because there's another comment you have got in a report where you said that the way in which data has been captured and interpreted has varied and you call that - I think it's called in the report - improvements. I'm trying to get a feel whether the data has been captured and analysed in a consistent way or are we going to have variations and what we're looking at is not necessarily reflective of the information that we need.

Mr DOCHERTY - Ms Alexander, it's Brendan here. The transfer of care is defined as 30 minutes across all jurisdictions including Tasmania as per the Australian College of Emergency Medicine. In Tasmania, we also record anything above 15 minutes heading towards the 30 as another point of care for us in terms of we can capture the data to see if we need to then do something different before we get to 30 minutes. They are two separate timestamps. They help us manoeuvre locally within our emergency departments and ambulance services Tasmania, but it's not a key performance indicator that is shared across the jurisdictions. The 30 minute is the indicator where we are focusing our improvements and our standards.

Ms MORGAN-WICKS - But we are also looking at improvements, Ms Alexander, in terms of technology for digital ways to improve the accuracy of our data recording, noting that every time a paramedic's attention will be on providing patient care to the patient, is there a means by which, for example, we were able to digitally record the passage of a patient onto ambulance from arrival to hospital like we do through our TasGRN systems, noting the location and time taken for ambulances to move to hospital and where, for example, if we got to the location of adverse events, for example, within emergency departments that we could also track. Whether that is through some kind of recording device that moves with the patient or with the stretcher or with the paramedic and certainly that has been the subject of conversations within our digital health transformation and how we could resource that. But we want to see, noting staff feedback and we would have to consult very closely with staff, about that use - that it was safely provided and have a look at other jurisdictions and how exactly they're recording it.

CHAIR - Is it true that the 30 minutes and the 15 minutes, that the clock starts for that only once the person is triaged? An ambulance arrives, and my understanding is, it only occurs when the person gets triaged, that is when that time starts. A patient could arrive on the ramp with the paramedics, and it could be 10 or 15 minutes before they could be triaged and then they might be ramped for 30 minutes. It could 40 or 45 minutes they have been on the ramp but that early part is not recorded. Is that true?

Mr EMERY - Thanks, Dr Woodruff. We record the arrival of all ambulances from the moment they arrive. We have identified areas for improvement within our recording system where paramedic status can change to ramped and that status change might occur after a triage has taken place. Mr Webster's point earlier is correct that the rollout of the Tasmanian Government Radio Network means that paramedics can now status themselves off their portable radio which will allow for more comprehensive and accurate data intervals. An important part of the consultation that has been underway around the mandated transfer of care is clearly defining that arrival at hospital by the ambulance is the starting point and off-stretcher-ing of the patient is the finishing point and that will be what defines the period of transfer of care.

CHAIR - Excellent, thank you very much. Ms Morgan-Wicks, yesterday's announcement - which Mr Webster spoke briefly about before which relates to triage patients, I think probably categories 4 and 5, who are on the ramp and the protocol for getting them off the ramp - that is something that staff have been talking about for years now. It is great that it has happened, but it reminds me of the comment that you made earlier in your opening statement where you said, 'I listen to staff and personally go and do that'.

I am sure you do but how do you respond to the many comments that we have had from paramedics and other staff that they have had good ideas or concerns that have been blocked from going further up and having any action taken on them. There can be many reasons, personalities in the Emergency Department - possibly personalities - senior Ambulance Tasmania staff where there doesn't seem to be a process where true consultation can occur and provide a safe space for staff on the ground to be heard and listened to and have a response in a way that takes them out of the frame of, I suppose, the workplace politics or individual personalities. All these things have been discussed and commented on. What can you say to that?

Ms MORGAN-WICKS - It is a very good question, Dr Woodruff. As I have discovered, since working for Health, and I came over as secretary at the end of 2019, I thought I understood hierarchies, certainly from my legal background and working at the Department of Justice. Certainly, we have significant hierarchies at play within the Department of Health, within Ambulance Tasmania, within departments within hospitals and these are borne not just from clocking on as an employee of the Department of Health but through everyone's training, certainly significant professional silos that can occur.

I absolutely understand when staff say, 'I feel blocked', or, 'I am not able to progress an idea', but we are trying to encourage staff to come forward. That's a real focus of our One Health cultural improvement program to try to provide everyone with that voice but also equal voice. That has been something I have been trying to encourage, as secretary, particularly between professional silos and divisions and a real reason why we have attempted to change the governance structure to bring everyone together as one team and to treat it as one patient.

Mr Emery, for example, spoke that it is not Ambulance Tasmania's patient, they are not the Royal's patient, and they are not community care and subacute step-down team's patient. It is one patient that should have a single journey. We should also open up to our private providers to share that information so their treatment can continue.

CHAIR - Do you have a model in place, or can you imagine proposing a model that would be a safe, confidential space for staff to be able to provide information and be responded to? Recognising that the pressure cooker that people are working under across the hospital, especially paramedics on the ramp, especially in the emergency department and also on wards, means there can be many reasons why people at senior levels want to control a situation and not necessarily report on concerns and complaints. That's a very dangerous and potential toxic culture, and dangerous for a patient's health. that needs to be managed. How do you propose managing that?

Ms MORGAN-WICKS - Which is why we are very focused on improving the culture across health and have been working with all of our staff in relation to that. But that is a multi-year process and certainly one in which Tasmania is not alone.

If I may comment on ideas about access solutions, I think everyone at the table will appreciate the many solutions workshops, round tables, opportunities to consult, means in which we've put out, for example, a suggested draft policy, of trying to get things into enterprise bargaining or other awards and agreements, for example, to try and embed that change.

For all of our staff, I really do encourage them to come forward and voice their views without fear of hierarchical pressure, and certainly they do. You should see the emails I receive or the many times I'm stopped as I wander around the hospital with information. Somehow, we need to take all of those bits and pieces that come through, noting that some feel worried about putting their hand up to provide a suggestion. But doing that, bringing it in and prioritising that list.

We've been very public with all of the improvement initiatives we have across our statewide access and patient flow program, inviting staff and publishing continuously to them to invite their feedback on particular initiatives, or 'you haven't got the order right, I think you should do No. 7 first'. We also have our Emergency Department Network that includes both Ambulance Tasmania and representatives across every ED. Every ED is different in Tasmania, and they will have their views on the priority and why sometimes we'll try something in the north-west first, or in the south first, before taking it in a statewide fashion.

There are multiple opportunities to try and encourage staff to come forward and to share those ideas with us. But it is often, as the ED reviewers found, here is the list, you have the list of issues that need to be improved; it's the change management and then the effort to try and get that change occurring in our hospital environment, across every shift that changes over, different staff that then start, to keep them trained and up-to-date on protocols, noting where they are not complying with protocols and procedures, and trying to continue that training. I can't pretend that that's not a really difficult task, one that, for example, by having a dedicated deputy secretary responsible for hospitals and responsible for trying to achieve the change working with our chief executives. They've been dealing with pretty hard dates under our ED review to achieve that type of change for a workforce that is pretty change-fatigued. The level of change we've had to roll out through COVID-19, through a pandemic, to meet growing demand and to continue to improve. I absolutely respect that people are tired but trying to

make sure we hit them with the most significant priorities for improvements as we move forward and provide them with enough training, confidence and support to be able to do it.

CHAIR - Is there anyone at the table who was involved with Mr Emery and a conversation with him before he sent the letter that was received by the committee that I was talking about earlier today? Did anyone provide any advice to him about that letter?

Ms MORGAN-WICKS - My recollection, and I did have different periods of leave through January, so I'm just trying to get my dates right in my mind, is that we did have conversations. We had weekly conversations about access and flow, about our ED review - I should say fortnightly at Health executive and then the alternative fortnight at our THS executive, and about preparing, noting the evidence that's coming forward to the committee, whether there's additional data or other information that we can provide. I recall that general conversation at Health executive, and also to prepare for our appearance here today. Certainly, if at any -

CHAIR - Did anyone recommend that he should send a letter, unsolicited, to the committee, about evidence that had been provided?

Ms MORGAN-WICKS - I'm not aware of that. But I also note that my chief executives are very senior and experienced people who will make a call-in relation to information that can be provided. It is certainly within their level of expertise, and they've -

CHAIR - Did they make a call about that and have the conversation with Mr Emery?

Ms MORGAN-WICKS - I didn't have a conversation -

CHAIR - No, did your senior executives? Did anyone here?

Ms MORGAN-WICKS - I'm not aware of -

CHAIR - When you said that's their job, or that's what they would do, who are those people? Did they talk to Mr Emery about that?

Ms MORGAN-WICKS - With respect, Dr Woodruff, we've also received various forms of direct correspondence from the committee, so it hasn't all come in through a centralised process that I'm aware of. People have received -

CHAIR - It has all come from the committee's secretary. No members have sent any correspondence to your department. It's only come from the committee's secretary.

Ms MORGAN-WICKS - Oh no, sorry, I wasn't suggesting individual members. The secretary has sent directly to individual members of my department in response, and I've seen letters addressed to individual members of my department. People have received correspondence that they may also wish to provide information individually on, as any employee of the department can do as well.

CHAIR - We've talked about that letter that came from Ambulance Tasmania. It did name staff multiple times and that is the sort of thing that people understandably feel nervous about; actually, being honest and candid about their concerns with what's happening with

management, or what's happening in a situation. And so, you've got a disparity where, on one hand, you're saying, 'I sit down and I chat with staff, and I have this friendly relationship', but then we're hearing from people making testimony to the committee that they're shouting into the wind and they're not being heard, and there's a resistance to being heard.

I suppose, from the committee's point of view, we'd be concerned to want to make some recommendations about the way that staff are working in very much less powerful situations, usually in a relatively powerless situation, in a hospital can actually make change when they're the ones who are confronted with situations on the ground and they're seeing changes that need to be made, but they're not getting moved past their senior levels. All of the general processes you talked about don't seem to address the safety issue for individual workers to be able to make recommendations for change. It feels like there's a gap.

Ms MORGAN-WICKS - We have absolutely encouraged our staff to provide information to the committee and shared information about the committee itself. We've encouraged their active involvement in the emergency department independent review -

CHAIR - Sorry, I meant in an ongoing way, not for the purposes of this committee but in general. Do you think there needs to be a safer mechanism for staff, where they don't feel there's any reprisals for them and they can make confidential comments?

Ms MORGAN-WICKS - In terms of that, we've also heard that, for example, through the commission of inquiry. There are multiple mechanisms and I've spoken to our staff about the multiple mechanisms that they can utilise to provide information to me as secretary, whether it's through protected information disclosure, whether it's through a complaint email - and my email is no secret, I think, to anyone that's in the community or for staff because I receive those. This is why we have implemented that centralised complaints management process to receive them.

But I do encourage every member of our executive, including Mr Emery as our chief executive of Ambulance Tasmania, to be out, to be walking the floors and to be proactively engaging with our staff so that we develop those relationships so that information does flow.

We also have to empower -

CHAIR - It sounds like Mr Emery does that. Obviously, he's working closely with his staff.

Ms MORGAN-WICKS - And our new chief executives of both the Royal and also the Launceston General Hospital and the North West Regional and Mersey Community hospitals.

CHAIR - I've got some other questions following on from what Ms Dow's pass was talking about: discharge planning. Mr Webster mentioned that discharge planning, or one of you mentioned that discharge planning is something that is not just an end point for a discharge officer; it has to start at the beginning. We had information provided by an emergency department nurse unit manager who was very clear that the changing profile of people who are now coming to the emergency department, which will continue to change, is older people coming to hospital after a fall or with some signs of delirium, which could be dementia or not. Their first port of call into the hospital may well be on a pathway to needing to move out of home and get some aged care support. That person was very clear that the conversation needs

to happen from the emergency department moment, not just with the patient and across the hospital, but with the family, engaging the family at the very beginning. Recognition that, if you know that this person is going to go upstairs and they might be there for a week, you need to start on day zero with thinking about discharge planning and preparing the family. Is there an intention to be undertaking that specific level of expertise, which would require geriatricians and counsellors located in or around the emergency department, it sounds like?

Ms MORGAN-WICKS - Before Brendan starts, one example of the work underway is our aged care collaborative, trying to work with our residential aged-care facilities, working on the really positive relationship that we extended throughout the COVID-19 pandemic, for preparation. One of our biggest issues is that it's not day zero, at the point of a fall and an elderly patient coming into the emergency department to start that conversation between family members. It's actually about that planning also within families in the community for what is going to happen to their significant loved one, if they are noticing rates of deterioration, in the different community services that can be accessed.

But to properly plan for discharge and to expect that conversation if you are an admitted patient, to actually know what your estimated date of discharge is basically from day one and to start making those arrangements, which is incredibly complex for some patients that have no plan, no preferred residential aged care facility or respite, for example, let alone NDIA adjustments.

Mr DOCHERTY - I might add on, Chair, we've recently opened eight Hospital in the Home beds specifically for geriatric evaluation which means, hopefully, those patients aren't even coming to the ED. We can have the geriatric evaluation Hospital in the Home team then see the patient in their home to help start some of those conversations.

CHAIR - When you say you've opened eight beds, you mean there will be services to provide support for eight people in their homes?

Mr DOCHERTY - Yes, for geriatric evaluation as part of the Hospital in the Home model. That's a start, that eight beds. We can obviously evaluate and keep going and seeing what the need and demand might be.

CHAIR - Are they across the state?

Mr DOCHERTY - No, they're in the south as a pilot.

CHAIR - Is there any reason not to do a pilot up in the north and the north-west?

Mr DOCHERTY - The north will be piloting their new 11 beds very shortly to open -

CHAIR - Not aged?

Mr DOCHERTY - Hospital in the Home generally, not aged, not yet. But through the ED review model, we have some amazing clinicians who have formed communities of practice, and those communities of practice are multidisciplinary across our three regions. In the south region they are very passionate about general medicine and geriatric evaluation, as well as geriatric syndrome models of care, and they've asked for some assistance from their executive to look at doing that differently to address these issues that you're talking about.

We've got an internationally renowned leader in this field, Professor Brian Dolan, coming to visit us in February to enable that model of care review and model of care change with those teams at the Royal with the hope that will also connect people up across all our three regions to then be part of that to see if that applies to them. Then we'll do it differently in all our regions as well. That's quite an exciting piece of work. Again, it's coming from our clinicians and from that community of practice. They're certainly very keen on working hard on that model of care. Professor Brian Dolan is fairly famous around time being the most important currency.

Also, this thing about deconditioning and having very active days of therapy for our patients. We hope that reinvigorates our teams to think differently and to come forward with more ideas around what they think we can do differently and how we enable it.

CHAIR - Would you look at having something to support the family who might be attending the emergency department, which might be the first place where those conversations start? Are you investigating that as an option?

Mr DOCHERTY - One of Brian's expertise's, he worked originally with NHS improvement. We would actually have geriatricians in the emergency department or a geriatrician nurse practitioner, for example, to be there to look after our frail elderly and fast-track them through a different model of care to make sure we have early, quick decisions and discussions with family and the patients themselves.

Mr WEBSTER - Outside of the hospital space at the moment - this is looking at the hospital avoidance space, which sits within Older Persons Mental Health Service - the reforms we are doing there are focused on community rather than inpatient. We are working with people while they are still in their homes, when they are still at residential aged-care facilities, to support them staying there even though they may have mental health overlays that would generally see them flow through the hospital to Roy Fagan. We want to keep them in their homes, so there is a trial of a rapid in-reach program for residential aged-care facilities which is happening in the north. We have decided to do it in the north given that GEM (Geriatric Evaluation and Management) was happening in the south. Also, the federal government has funded Glenview to do a model around dementia, and overlays of delirium and mental health. The team working with Glenview are from within the department. So, there are a number of initiatives there.

CHAIR - What about regional hospitals? That has been mentioned by a number of people presenting to the inquiry that regional hospitals are terribly underused in Tasmania. Particularly, rural doctors were questioning why regional hospitals aren't used more for step-down, particularly for those older patients who seem to be taking up - it is not their fault but spending long times in beds because they can't find an aged-care facility or appropriate at-home help. Why aren't regional hospitals being better utilised for this?

Mr WEBSTER - There are a number of federal programs that fit into that space of; one is transition to care program, which sits between hospital and a final placement in residential aged care. They can be both community placements or at an aged-care facility, and they are funded across the state. We broker those spots, but they're delivered outside of the THS in the north and north-west, and some of it is delivered in the south by the health service.

CHAIR - Given that these are people who are taking up space in our hospitals, arguably it is about patient flow through the system, isn't it? It is about finding another bed.

Mr WEBSTER - Absolutely, that's right. We work with the aged-care facilities and aged-care providers to fill up every one of those transition to care places so that they are constantly full, so we have that flow into those.

The second part of it is, Brendan mentioned, on day one you have to identify that this person may end up in aged care, so you've got to start the process of aged-care assessment, et cetera. I would argue, because I've had this happen in the past, we should be talking to families about their enduring guardianships, about their advanced care directives, when they are 18, and keeping those up to date because if families are not having the conversation about the possibility of aged care and those sorts of things, and the first they are hearing is at the ED, that will naturally take more time. My plea to everyone is that we talk before we get to hospitals, we communicate about what are the options for our ageing population and get people to make those choices before they become frail.

The last thing I'd say is that last week was the first meeting of our frailty network. That is a network that is system-wide, it is not just health service. It brings in aged-care facilities, private providers, GPs, as well as the THS, working on what are the ideas for how we deal with frailty in the population in Tasmania. The first meeting was last week. That is a clinical network that will develop soon.

Ms DOW - I wanted to ask you again about those eight beds that are being trialled in the south. Is there not a view to do anything in the north-west?

Ms MORGAN-WICKS - We will evaluate the pilot and trial. We always look to apply those learnings when it is a positive outcome from those trials to a statewide perspective, noting that we also need to -

CHAIR - How could it not be a positive outcome? It is hard to imagine how it couldn't be a positive outcome.

Ms MORGAN-WICKS - It is hard to imagine how we have not had Hospital in the Home beds for many years within some of our environments.

CHAIR - Do we still need to learn that?

Ms MORGAN-WICKS - It is not always a case of learning; it is actually getting the clinicians empowered and involved and wanting to implement Hospital in the Home beds. We have had, for example, I do not want to get this number right, but it feels like 18 Hospital in the Home beds -

CHAIR - Don't want to get it right or don’t want to get it wrong?

Ms MORGAN-WICKS - Sorry, I don't want to get it wrong. It's late in the day. We had some 18 general Hospital in the Home beds available at the Royal Hobart Hospital, but it requires clinicians to be confident to transfer a patient into that Hospital in the Home care and to know that they do have that wraparound and primary care support that will assist following

the conclusion of Hospital in the Home. It is a process of change management. It is not trying to put up every barrier to stop those fantastic ideas.

I will comment in the same way with our support for the amazing work the district hospitals and our community health centres provide. We have conversations many times a day in each of our integrated operation centres in our hospitals, trying to get patients out, for example, to a regional district hospital bed. Often one of the major barriers is the distance from where they are at the LGH or at the Royal. New Norfolk seems to be the exception to that rule, with quite significant public support for a transfer to New Norfolk as a step down. But it is quite difficult often with some of the other district beds. We have had conversations as an executive, particularly through COVID, about that risk, enforcing a transfer of a patient, perhaps against their family's wishes, but noting that also the support of visitors is an issue in that conversation.

CHAIR - You would agree that it is worth investigating and pushing more resources into that area as a way of moving people through the hospital?

Ms MORGAN-WICKS - Which is part of our integrated operations centre: look at every single bed that is available within our health system to try and encourage and find the right patients to transfer into those beds. We ask the community for their support, that if their loved one is in a bed that is not requiring the level of acuity of an LGH, Royal, North West Regional or Mersey, they could go to a district hospital bed and allow another to take their place. That is that community conversation we need to continue to have.

Ms DOW - Just one more question, going back to the point you make about enduring guardian and advanced care directives, Mr Webster. We speak a lot about those things and the importance of people having them, but there is not a lot of education in the Tasmanian community about the importance of them. Is there a plan, as part of all of this work that you are doing, to do an awareness campaign in the community about the importance of those particular documents for people?

Mr WEBSTER - I state that because I used to run the training course on how to do them. There is a program across the THS to encourage people to do advanced care directives, enduring guardianship. The Public Guardian runs a program as well, and also TASCAT run a program to encourage people to do those.

Ms DOW - I was also thinking about more as a proactive measure before people actually enter the THS so that they are well informed and that then translates to the care provided when they present.

Mr WEBSTER - Yes, and as I was saying, the Public Guardian has the lead education role in that space. But in thinking about it, I think we all have a role in promoting those. I did want to comment on your question, 'Is there a trial in the north-west?', and answer yes there is. One of the trials we have underway is a 12-month trial with OneCare, which will involve our district hospitals over the next period where we're identifying patients that are not quite ready for aged care, still need some support, and then working out what support that is. They go to OneCare, but we might be providing allied health support from within the hospitals, or it might be supplying them with a clinical nurse educator to do a session with their staff to learn about the needs of that particular patient. It's a whole range of provision where we sit down with OneCare and work out, 'If you're taking this patient, are you ready for them?' and, if not, 'What

can we do to support you?'. That is a statewide trial in all regions at one time. That's underway and started, Brendan is going to give me an exact time line, but late last year.

Ms DOW - My last question. We've had conflicting information presented to the committee. Are there ACAT assessors based permanently across the acute sector or are they only in the community?

Mr WEBSTER - The short answer is yes but there is a model change occurring at the federal level that will see the ACAT assessors being based across both acute and community sectors, so the one person doing both. At the moment, the THS does the acute sector and the outsourced ACAT from the federal government does the community sector.

CHAIR - Thank you. We are out of time, but I want to finish with one question. We've heard from multiple people who have presented, from people in the emergency department, paramedics and nurses, that a critical problem with access flow in the hospital is a lack of cleaning staff and allied health practitioners - the cleaning staff to clear rooms not working seven days a week and there simply not being enough allied health staff to support the needs of the increasing aged population. Is there an intention to increase the resourcing of both of those integral parts of the access flow issue?

Ms MORGAN-WICKS - Our staff are correct. Without sufficient housekeeping and cleaning, food, nutrition, allied health support, et cetera, those are all critical impacts on flow. Certainly, we've been looking at an uplift in our cleaning and domestic teams across each of the hospitals. I can't put my hand exactly on the data, but we have seen a significant increase, obviously also through COVID, in terms of trying to keep up with the level of demand and staffing beds, with our first focus, obviously, on medical practitioners, the nursing staff to support. But if we don't keep up in terms of the allied health investment and also the support services that are around each patient, that is going to have a significant impact.

We have seen an increase in terms of our cleaning resources. Would I like to see more? Yes, I would. We have also seen some real success from our allied health scholarships. Really pleased to see quite a significant increase in our allied health practitioners, thanks to our University of Tasmania partners hearing from our staff and the department's advocacy to be running programs on island, so that we can then fund placements so they can train, for example, in physiotherapy, which has been very positive.

CHAIR - Very important. Thank you all very much on behalf of the committee for all of your time and the evidence you provided to us today. It's so important to the inquiry.

I remind you individually and collectively that the evidence you've provided to the committee today is covered by parliamentary privilege. If you walk outside and say things, that could mean that you might be sued or end up in court. You're not covered by parliamentary privilege. Thank you very much for presenting to our inquiry.

The witnesses withdrew.

The committee adjourned at 4.40 p.m.