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THE PARLIAMENTARY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON TUESDAY 23 JANUARY 2024

The Committee met at 9 a.m.

CHAIR (Dr Woodruff) - Good morning, John and Simone. Online we have Simon Wood, the member for Bass, and he is in the north of the state. In the committee room we have Anita Dow on my left and Simon Behrakis on my right.

John, we do not need to swear you in because you're not in our jurisdiction, so you don't need to have the rules of evidence of the committee. I will ask Simone to introduce herself and state herr name, title and organisation. Did you read the information that Fiona Murphy, the secretary, gave you?

Ms HAIGH - Yes, indeed. I have actually appeared before in this inquiry.

CHAIR - Yes, that's right. I just needed to go through that again and say you understand that it is a proceeding of parliament. That means that what you say gets the cover of parliamentary privilege. That is a legal protection that allows you to give evidence without fear of being sued or prosecuted or questioned in court outside of parliament. That protection does not remain with you after you leave the committee meeting today if you say anything defamatory outside that could be used against you.

This is a public hearing so there could be people from the public or journalists present, and your evidence could be reported. If there is anything you want to say in private, let me know and the committee can organise to go into an in-camera setting. Is that clear?

Ms HAIGH - That is clear.

CHAIR - Thank you. Can you please introduce yourself and tell us your name and title of organisation.

Ms HAIGH - Simone Haigh. I am a part of the Australasian College of Paramedicine. I am the director and the vice chair. I am also an intensive care paramedic with Ambulance Tasmania.

Ms SIMONE HAIGH, BOARD DIRECTOR AND VICE CHAIR, AUSTRALASIAN COLLEGE OF PARAMEDICINE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED VIA WEBEX.

CHAIR - Thank you. Do, I need to ask that of John? No, I don't, because you're in another jurisdiction.

Thank you very much for coming today. We've got your submission, and we thank you for the detailed amount of evidence that you provided to the committee already in your submission. We've read it and we've got some questions to ask on the basis of that.

Do you have an opening statement or any preliminary comments that you would like to make first?

Mr BRUNING - I have an opening statement, Chair.

On behalf of the Australasian College of Paramedicine, I thank the Chair and members of the committee for the opportunity to contribute to this important inquiry. Our health system is no longer fit for purpose. It was really built for acute and emergency patient presentations. While we've continually added on and extended the health system to try to meet our changing needs, it simply isn't working. We have an ageing population with chronic and complex health conditions that require ongoing healthcare and management. We also have growing mental healthcare issues. Our tertiary hospital system is not designed to manage these patients effectively. We need to be managing the ongoing health of our community in the community.

Transfer of care or ambulance ramping, access block, is a symptom of inpatient hospital services unable to meet patient demands, the inability to move acute patients from emergency departments to hospital wards, and the safe discharge and out-of-hospital care of patients. That leads into general access to primary healthcare, which sees people's conditions worsen to the point of calling triple-0 and needing a paramedic or transfer to hospital.

Ultimately, ramping and access block highlights a health system in distress. The key issue is the inability for the community to access the right care in the right place at the right time. We are all aware of the issues in the primary healthcare system and the community access to it. I think we already know the solutions: appropriately resourced, equitably distributed, universally accessible and free primary healthcare would address many of the issues experienced by our ambulance services, emergency departments and hospitals.

Before, non-life-threatening, non-urgent conditions were treated in the community, whether in a clinic, home or aged-care facility by a multidisciplinary team-based care. Most non-life-threatening but urgent conditions were treated in larger clinics and urgent care centres. That will actually have gone most of the way to resolving our healthcare issues.

Speaking specifically about paramedicine, we became a registered health profession six years ago, but we've not really been appropriately considered and embedded in the health system outside of traditional ambulance service emergency response. Paramedics are independent practising clinical experts in urgent and unscheduled care, as well as managing acute presentations of chronic primary healthcare issues and mental health presentations. Paramedics are capable and comfortable treating patients in any setting, almost like no other health profession today, and must be a key part of the solution to deliver the community healthcare required in Tasmania today and into the future.

We look forward to discussing the solutions we put forward in our submission. Thank you.

CHAIR - Thanks, John. Simone, did you want to add anything to that at the start?

Ms HAIGH - No. I have nothing to add, thanks, Chair.

CHAIR - John, you mentioned at the end about paramedics are a registered profession but aren't properly recognised and that there is a great opportunity for expansion of practice and training and expertise. We'll come to that because that is in your submission and it's a very important matter.

I wanted to start off by asking you to comment, from your expertise around multiple jurisdictions in Australia, what you've observed in Tasmania over the last five to 10 years. The evidence of the data shows that there has been a steep increase in ramping, and we've heard the impacts on staff. I would like to hear your perspective on what you've observed the changes have been and how they are impacting in recent times.

Mr BRUNING - Yes. I think the matter is reasonably consistent across jurisdictions bar the ACT, which is a much smaller geographical area. It has some different requirements there, but generally across most jurisdictions there are now widespread challenges with ambulance ramping and access block.

I've been in my role 11 years, so I've had a good look what is going on as these challenges have increased. It really comes down to we are at this crunch point of less access to primary care in the community, seeing our patients in our community become more unwell because they cannot access care. Therefore, they're turning to other means to gain that care they need.

This isn't a new experience for paramedics. It's been quite common in rural and remote areas that they become the only healthcare service when you clock off Friday at 5 p.m. until Monday at 8 a.m. There's nothing available for a lot of communities.

Paramedics, for quite a while, have been drawn into doing what is not emergency response, but providing community healthcare. That issue of access to primary care is probably a key driver. It plays to aspects to it in that, one, people are requiring care through the hospital system and through ambulance more often. But on the other side, we now have the hospitals getting full and patients aren't able to be safely discharged, we are then seeing that we get the bed block, an issue in the hospital. If we have someone of older age in a hospital, it's harder to discharge them out into the community if there's not appropriate care for them. We are getting both ends causing the issue. There're more people going in and less people able to come out because we don't have fully integrated and accessible community healthcare.

CHAIR - Thanks for that, John. No one would disagree with the fact that what's been happening with the decline of GPs in the community and the provision of care in the community is a contributor to what's happening with ambulances bringing more people to hospital, as you've said.

I'd like you to talk about a view that it is the lack of GPs which is causing the problems with ambulance ramping. Just to tease apart the issue of what you were talking about before, which is people ringing the ambulance because there is nowhere else to go, particularly in regional areas and then ending up in hospital and being a person who does or doesn't need a bed. My understanding is that access block is when a person who comes to hospital in an ambulance does actually need a bed and doesn't get triaged as a person who can be dealt with in the emergency department.

Could you just talk about the difference between people turning up to emergency and the extra load on emergency staff and people being held on the ramp because there isn't a bed for them to be admitted as an impatient in hospital? Surely, they would be the ones who need that bed anyway?

Mr BRUNING - Yes, it is an issue in distinction between those two, because we've two groups coming into ED through different pathways, obviously, one via the ambulance. We

have seen in some other jurisdictions where there has been some action taken to offload patients that they believe can just go in and sit in the ED and wait, so there have been some actions taken to try and free up ambulance services to return. Obviously, that can't happen with everyone. You're noting that they come in an ambulance, and they need to be admitted and need to then go into the hospital system. That group is always the group going to need that.

What we are trying to address is the ones that don't necessarily need this. Then once they're treated, how do we get them out of hospital safely and in a timely manner, so we continue to free up beds. The people, as you spoke about, the distinction between the ones that turn up and definitely need to go in and definitely need time in a hospital, they're the people that should be there. They're the people we want that care, but we need to work out a way also to see them move back out into the community rather than stay there longer term. We've got to a point where we are almost hospitalising our end-of-life care process, because we can't access care in the community.

CHAIR - The solution, which some would propose, of urgent care centres, for example, might help many of the people who need to have community primary care, but it won't do anything to stop the people who need to access a hospital because they need a bed due to the severity of what's happening to them?

Mr BRUNING - Yes, because that's the nuance in it, isn't it? Those people could potentially not be in hospital if they had access to continuous ongoing care in the community. We are talking about an older cohort of the community who have chronic health conditions and if we were better caring for them in the community, would they be requiring that bed? Would they be requiring that transfer to hospital? This is so complex and it's very hard to just say if you just fix this one thing, it will solve all your problems. We've got to work at it from a range of factors to address it. We can reduce the number of people going to EDs by community care and by urgent care clinics - meaning when the people who need that care and need to be in the hospital for a period can get there and get access. But then we also need to work out how we move them out of the hospital so they can go back to the community. I don't think most people choose to sit there and say, 'I want the last year of my life to be in a hospital'. We need to work out how care looks and how we can do palliative and end-of-life care in the community, rather than in the hospital.

CHAIR - Yes, thank you. I think we'd all agree with that.

One of the things you mentioned in your submission was the increased risk for adverse outcomes of people who are presenting at the emergency department when they are delayed on the ramp. These longer periods, according to the multiple areas of research now which show that relationship you referenced - New Zealand research - with a 10 per cent greater chance of dying within seven days of admission after people have experienced delays in admissions. Could you speak a bit more to that relationship? Clearly that's the evidence of paramedics who are on the ramp seeing adverse outcomes being caused because of a delay of appropriate treatment and care they can't give in that situation.

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

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

Ms DOW - Thank you very much, John and Simone, for presenting to our committee this morning. I'm going to take you straight to the recommendations you make in your submission.

John, would you elaborate more on the point you make in point (f) on updating ambulance deployment modelling in Tasmania and if you might highlight some of the issues you see currently about how that's working, and how you think it could be improved?

Mr BRUNING - Very good. I might check in with Simone as someone in the ambulance service to take a start on this one.

Ms DOW - Thank you, thanks Simone.

Ms HAIGH - No problem. Definitely, the dispatch - I believe - we have spoken throughout the inquiry at times about secondary triage, and things like that, that have been implemented within AT. However, secondary triage is not a 24-hour service; neither are the community paramedics. I believe there is an opportunity there to really provide better care and better outcomes, if we can have those clinicians 24 hours. Secondary triage does a lot of diversions away from ambulance, and they also do a lot of diversions to the community paramedics. On top of that, we believe it also needs an expansion of patient transport, because at the moment, they work during the day and then do on call of an evening when, really, they could be assisting with moving some of these patients around and getting them out of hospital.

It is really the dispatch (inaudible) we need in the secondary triage community paramedicine space. It needs a good investigation into what is going to be best for the needs of Tasmania because if we rely on other services, it is not necessarily what we need here. As you are aware, there is limited access to GPs, there is limited access to a lot of primary and preventative health. Palliative care is difficult to get into because they are just so overwhelmed with patients. I think this is a big opportunity for ambulance to be able to make a difference here with these patients. Urgent care centres have helped with the diversion to urgent care centres as well.

To answer your question, yes, there should be a bit more of a focus on the non-acute, non-high acuity stuff. As John mentioned, high acuity is not necessarily the bread and butter now of ambulance. We still are doing high acuity work, but because of the difficulties within the health system, our work has changed remarkably to low acuity and care within the community and trying to keep people within the community rather than into hospitals.

Ms DOW - How many additional community paramedics do you think there should be across Tasmania or the extended care paramedics?

Ms HAIGH - Probably significantly more than we have now. We have had one intake and many of those have left areas or have stepped down from the role. We probably need at least two to three per day. If we go 24 hours, then probably three per day in each region, at least. Probably, the larger regions, such as the southern region, probably needs two to three crews on per day of community paramedics to manage the volume of low acuity calls.

Ms DOW - Are these issues that have been raised through advocacy through your organisation with Ambulance Tasmania? What do you understand to be the barriers to these positions being created in Tasmania? Is it simply just a question of funding or are there issues around recruitment and retention that you can identify?

Ms HAIGH - I think all of those are important. Funding is definitely an issue but also recruitment and retention. We are also getting to a point where a lot of ambulance services in the last couple of years, because of COVID-19, have had a massive recruitment drive. We are actually starting to get to a bit of a sticking point, where there may not be enough graduates coming out of the system because it takes time for universities to catch up with demand.

Nationally, we are probably going to start seeing some difficulties with recruitment in the country. We also have to attract people, qualified officers from other states, which at times can be difficult with cost of living, particularly in Tasmania which has one of the highest costs of living in the country. It is also a big thing to come down here. We are not seen as particularly progressive at the moment. We have fallen behind in the last few years in Ambulance Tasmania with our clinical guidelines and it is not necessarily attractive for people to come down. There are a lot of different issues involved with recruiting and retaining staff.

Probably one of the biggest difficulties at the moment, which we discussed in the previous appearance in this inquiry, is fixed term contracts and no permanent employment. People are leaving because they want permanent employment rather than the insecurity of fixed term contracts.

CHAIR - Maybe Simone or John, whoever you think, following on from that recommendation in terms of the professional extended care paramedic extension of paramedicine. You said that there is the value of having specially trained health care providers and professionals to attend people in home care and aged care facilities, and that would have a dramatic, positive impact on keeping people in aged care facilities and helping with discharges from hospital. Can you talk about the EPC role in Tasmania and what blockages there are to expanding that?

Ms HAIGH - ECP and community paramedic are now in the same bundle, so ECP, we are probably at a point of grandfathering out the ECP because they were an intensive care paramedic and would have gone into non-acuity work. It is a bit of a paradox having your acute clinician doing non acute work, so that is where the community paramedics have come in and they are in that role and are specialists in low acuity care.

CHAIR - The recommendation that you have there or your comment that in your view, according to the research, 13 to 40 per cent of all transfers from home care facilities to the emergency department could be avoidable by providing clinical care within those facilities. That is a huge statistic given the increase in older people who are coming to emergency for the very reasons that you have been talking about. What has the response been from the

Government? Have you been in conversation with the Government about working in this space in particular to help with flow through the hospital?

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

Our recommendation is not just paramedics but team-based care, a multi-disciplinary team of paramedics, nurses, GPs, doctors who are able to work together and provide care, either in the home or in the aged care facility and means that they do not go to hospital except when they need the facilities that the hospital provides. That is what we are transferring this group who do not actually need that care. What we have seen across jurisdictions is one of the big issues with bed block in the hospitals, with the emergency department, is the safe discharge of patients who have ongoing health needs.

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

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

CHAIR - Thanks. Are you aware of any jurisdiction, for example possibly Victoria, that is using this as a model or trialling this as a model in aged care homes?

Mr BRUNING - No, I have not seen anyone going at it at a state or federal level. I know that privately, because a lot of aged care is private, they are now engaging multidisciplinary teams to help with care. We now have paramedics in several aged care facilities providing care; Mercy Care, mainland and WA are using paramedics widely to help with the care they need. We are also going to have a challenge with the federal government's requirement to put a nurse in every aged care facility. It's just not going to be possible so we're going to see paramedics engaged in that fashion also. But paramedics are, as I said in the opening submission, used to practicing independently.

They are used to practicing in any environment. They are really highly valued in this state, and I think we're going to see more and more of teams of health clinicians. If I was running an aged care facility, I would have access to a group of doctors, paramedics, nurses, an OT and different health professionals that I could provide holistic care to take care of people in the facility rather than it going out. It costs them to do that and if they can pass that cost on to the hospital or to the federal government instead of them having to cover the cost, they're private businesses and that is what they do.

CHAIR - Are you aware of any evidence coming from those facilities or is it too early for data to have been collected to talk about avoided hospitalisations?

Mr BRUNING - I haven't seen any data at this point in time and it's only anecdotal. There was recently a presentation at a health workforce summit by the CEO of Mercy Care saying how impactful the paramedics had been in providing better care to their community, but nothing that is yet shown in the data in terms of addressing presentations to ED. This is what we need. We are in this chicken and egg situation where we're fairly sure it's going to make a big difference if you do it, but we need someone to go and do it and research to show.

There's a lot of examples internationally, especially with Canada, where this work is showing real positives. They now have paramedics at clinics. They have paramedics doing community care. There was a small group in Canada that were high frequency ambulance users and being transported to ED, so they made a community paramedic and a community nurse available to this group of 15 people. I think their figures were saving $ 1 million in a year by just taking care of this group of people in the community, rather than transferring them to hospital all the time.

CHAIR - Wow. Would the suggestion Simone made before about having community paramedics dedicated within each region and having crews on to deal directly with lower acuity issues be one way of delivering the outcomes Canada has achieved in that area?

Mr BRUNING - Yes. That's one of the things they do. They do that as well. One of the challenges as to why it hasn't been done yet in rural and remote Tasmania is there might be a feeling they are going to not have stuff to do for periods of the day, so they are ready to go when someone needs them, but what are they doing the rest of the time. In Canada they have worked that out by putting them in small hospitals, clinics or urgent care centres and do both functions. They are in a clinic doing work, now you need to go to the aged care facility, someone there is a bit more unwell, then they go do checks and do daily rounds to different facilities.

You need to build a mix of care, especially in rural and remote areas of how that community paramedic is working to get the greatest benefit. You want them available, and I think we got to the point where we expect everyone to be 100 per cent utilised and when everything is 100 per cent utilised as soon as you have a surge you have got a problem that people have to wait. You need people utilised not to 100 per cent, but if you can use them in other ways and then pull them from that to go to the care you need delivered you get the best of both worlds.

CHAIR - Thank you. Anita?

Ms DOW - Thanks, Chair. I am very interested in your recommendation 3 of introducing the role of a chief paramedic officer in Tasmania and take your point there are other senior health officer roles that provide advocacy to government and involved in health service planning. Can you elaborate on how you would see it working?

Mr BRUNING - Currently, we have one Chief Paramedic Officer in Australia, and that's in Victoria. They're a part time role, I think a 0.6. They work with the Chief Health Officer and the nursing and midwifery officer. That role has been in place for over six years now. The benefit we saw from that role and how it worked during COVID-19 in that all those health

officers were getting together and talking about the different roles that different health professions could play in providing care to the community.

What we saw in Victoria was paramedics used more widely and quickly than anywhere else. They were brought in to do testing and vaccinations and a whole range of things that other jurisdictions are going, hang on, paramedics just do the emergency response. We saw the impact of a chief paramedic officer to bring to bear the capabilities of a paramedic to support the health system were almost immediate. Really, they were able to save the health system some challenges by not going, 'They just sit over there in emergency response and now we're going to put a load of nurses into vaccinations and now we've not got enough nurses for other areas'.

It all had this flow on effect. They were quickly able to utilise paramedics because of that knowledge they had firsthand. There wasn't a competition between the ambulance service going hang on, I need my paramedics for this, and need to meet my response times and need to do this. There was someone just sit there and say objectively, paramedics can provide this for you. We can utilise them in this way. It's not going to impact the ambulance service, so we get the best of this group of clinicians to support delivery.

I think you're unlikely to need a full-time chief paramedic officer in Tasmania, but they would be able to bring to bear the knowledge and capabilities of paramedics to the health system and make it easier for you to utilise paramedics better to service the community. A couple of years ago, we heard there was work done in Tasmania in the Health department about bringing the chief paramedic officer, but that's gone quiet over the last two years. We thought this was going to happen for you a couple of years ago, but it's sort of gone quiet.

Ms HAIGH - To add to that, obviously, paramedics are involved with Health, but paramedics are also an emergency service and having a chief paramedic would not only help in Health, it would also help in emergency services, in crisis and disaster and all of those things that seem to be occurring a bit more regularly than they used to, like floods, fire, all of that sort of stuff. We get caught up in Health, but paramedics have skills in emergency response. A chief paramedic would be ideal, with a holistic approach to how paramedics can be used within the whole system, not just in health.

Ms DOW - Thank you, it's a very important point.

CHAIR - Simone, are you aware of chief paramedic officers that operate in other states? How would you make sure you could get the most of a position like that? To have that relationship so they wouldn't just be stuck in Health? I suppose some formal relationship with, as you say, Police, Fire and Emergency Management so that they could stretch across those systems, would be important.

Ms HAIGH - Absolutely. This is something the Government needs to sit down and have a think about how they would like to utilise that role. Obviously, Health would be a predominate area, but I could see them working for both organisations to really be fully integrated in the system. When the public thinks about Health, they don't think about paramedics. They think about doctors, nurses, hospitals and then when they think about emergency services they think about Police, Fire and SES. We're sort of forgotten in both sides and this would be a great opportunity to have a voice that really will positively affect outcomes for people either in disaster or in Health.

CHAIR - Sounds like a good idea. Can you explain to us how it would add value over the fact we have a Chief Executive Officer of Ambulance Tasmania? How would it be different than the role that the head of Ambulance Tasmania holds within the Department of Health?

Mr BRUNING - One of the challenges you have with the ambulance service, and what the CEO and I have found with our engagement especially across other jurisdictions, is that they have their statutory requirement and their KPIs, and their role function is to deliver those response times for you. So, if you get there one day - and looking at what paramedics can do with community paramedicine - you might think that, separate to the ambulance service, the ambulance service should be focused on the emergency response and community paramedics could be engaged in a different way to provide care to the community, not by the ambulance service.

I think as soon as you start to see that there are potential competing roles between what the ambulance service needs to achieve, what the health system needs are and how paramedics can play a role, is that you could have a clash there. Well, I don't really want paramedics there because it is going to make my job harder, but I see that it could make the health system better. Now you are lucky in that your current CEO has a great, holistic view of the whole health system and, I guess, the capabilities of paramedics to help across the system, but you will not always have those type of CEOs. They will change over time and therefore it is bringing a different perspective.

If you want to get input to a decision about what is going to happen with paramedics, if you just have one voice then you have just got one view. If you have a second voice, the chief paramedic officer and the CEO, then you can start to gain greater insight as to the role paramedics can play just by bringing in a second voice to that.

Ms DOW - Can I just ask a further question on that, please? So, you would see that role as being more strategic, and when you talk about community paramedic roles, would you see those being able to be employed through the framework of primary healthcare in Tasmania rather than through Ambulance Tasmania? I take it that is what you meant when you referred to that. In other states, are there examples of that where they are not directly employed by, or the ambulance service is not directly responsible for the management of those roles? That they are more embedded in the primary health service run by the state or community-based health services run by the state in those jurisdictions?

Mr BRUNING - Yes, so that is what is coming. We are seeing it happen in the private space. My team and I are in discussions with a number of primary health networks around the utilisation of paramedic teams working as community paramedics. I see that it is not one size fits all. In some areas they will be engaged by the ambulance service and that is the best delivery model, and in others it will be engaged by the primary health network, or it might be engaged by the state government because they work in a health clinic.

Where we see them being is that they will be engaged across the health system to meet the needs of the community, where it is required. Then it will come down to who is the best employer model to make that delivery possible. We can look to the UK. The UK has had registration for almost 20 years. They now have paramedics working across and within every part of the health system. They are employed by GP clinics. They are working directly with a

GP and doing home visits. They are employed by the ambulance services, but they are employed in emergency departments in the health system, in local health networks.

They are employed across the health system, and it is a case of what is the care the community needs and who is best to employ that paramedic to deliver that.

CHAIR - John, in your submission, you talked about expanding extended care paramedic programs further into rural areas. You mention that the Health department should consider implementing extended care paramedics across the state to work, as we have talked before, alongside GPs, nurses and allied health professionals. Can you talk about how you see extended care paramedics in that situation complementing or working with nurse practitioners? What is the relationship between those two relatively newcomers into the health primary care provision space?

Mr BRUNING - Thank you. There are a lot of complementary aspects of what paramedics and nurses can do and I know it would be seen that there's an overlap but it's not role replacement or one group trying to take the work of the other group. I think that they're complementary and we have good relationships with a number of the nursing groups, talking about the role paramedics can undertake to support better health care.

If we look at the matter from the perspective of what does the patient need and what does the community need, and not get into the, 'Well, this group normally works in this space and there's another group who wants to work in this space'. If we go to how do we provide the best we can for the community, then that is actually a mix. It's GPs; it's emergency doctors; it's nurses; it's nurse practitioners; it's paramedics; it's community paramedics. There's a whole group and we have a health care shortage so really, who can we get to work in that space?

Currently, we have a 9 per cent year-on-year growth in registered paramedics. We have had a mass hiring but it's likely that before COVID-19 half of our graduates couldn't get jobs. We had 1000 registered Australian paramedics on the UK register working in the UK, so we have great interest in being a paramedic and there are opportunities for paramedics working collaboratively with nurse practitioners, with nurses and with GPs to provide the care we need.

There will be some overlap, but there's some overlap across most of the health professions in terms of what they can do. If you have a nurse, nurse practitioner, a paramedic and a GP, you actually have a full range of care from acute, which the paramedic brings more of, to the chronic, which maybe the nurse practitioner brings more of, to the GP, who is like the team captain of this care. We can get fantastic care for our community by looking at that team model.

I don't see there being a competition or an issue; I think they can all work collaboratively together. We are seeing paramedics engaged in rural hospitals and small communities where they can't get any other health clinicians. They are not an emergency doctor but it's either nothing or -

CHAIR - That's right.

Mr BRUNING - utilise a paramedic or a nurse practitioner, so why would we not use those skills in those environments? We can all work together and we can all provide better care that way.

CHAIR - Yes, that's a very sensible approach. Can you talk about who is the orchestra conductor in that situation? What we have, speaking about Tasmania in particular, in regional communities, but also everywhere where there's a lack of primary care provision for people in the community. We have a mix there of federal funding, private and state - at least three - and sometimes non-government organisations as well. From the state Health department perspective, what is the role to step up the provision of healthcare services in the community to prevent people from ending up in ambulances and going to hospital? What is the job of the state Government? What would you recommend to them as the next steps to take?

Mr BRUNING - Great question. You're right about that challenge between the federal and the state funding and where this should sit. What we see, and the data that we've looked at from the Australian Institute of Health and Welfare (AIHW) regarding hospital presentations and the cost to hospitals and the ambulance service is the state budget.

When you have someone present to ED, it's roughly a $600 cost. When someone uses an ambulance, it's a $1000 cost, so that's $1600 every time someone gets transferred to hospital. Before you start, they go in and spend days in a bed and those sorts of things. Obviously, at this point in time, going to see a GP costs anywhere between a bulk-bill and the federal government paying about $40 to then some billing happening to the patient of another $30, $50 or $60. To see a GP is about $100.

To go through the state system in a hospital can be $1600, so if you look at the costs that the state Government have, that is the hospital and the ambulance service, if you are able to divert a small number of those people presenting to ED, whether it is walking in or via the ambulance service and treat them in the community via a mobile primary-care or mobile community health service that includes paramedics and nurses.

You have spoken about the captain there. I still think that the GP, in terms of integrated care, is that sort of captain of the healthcare team because most of us have a GP or GP clinic that we are part of if there is still some oversight there. But the cost, surely, will be lower than $1600 to treat people in their home and take care of them that way, even if it is ongoing over months. If they still present to the hospital three times per year and you were to provide ongoing care to them in their home, it is probably going to be cheaper.

You can look at it and say this is a federal government funding issue because it is primary care that is causing this issue, but you will make savings if you address it and address it in the community. It is sort of, yes, you are stuck there but I know that it will bring benefit to you, to the state budget and provide better care to the community at the same cost that you currently have.

CHAIR - Thanks for clarifying that. I think that is a very important point. It is about diverting the resources that are already being spent in a way we know is causing avoidable harm to people, including for some people the increased risk of dying as a result of the system that we are offering at the moment with the ramping. As well as all the stress, pain and moral injury for the staff who are working in emergency departments and especially paramedics, which is leading to people walking away. We have a real spiral situation happening.

To go back to the ramping issue, to finish up on what we were talking about before, do you think there is any work that needs to be done in Tasmania to better understand the adverse

outcomes we know are happening on the ramp because of the testimony of paramedics and, by implication, because of the data from other jurisdictions? Would you recommend that some work be done here on finding more about those risks?

Mr BRUNING - I think the risks are understood for us. Like I said in my opening statement, we know what the problems are, and I think we know what the solutions are. We can continue to research around why it is happening and what is going on or we can just get on with the solutions.

I think too often we are spending time trialling all of these different things. We go, 'Oh, they don't quite work'. A lot of the things we trial probably address 70 per cent of our problems but we go, 'Well, they don't fix everything so I will try something else now'. I think we just need to put our money where our mouth is, and we just need to pick what we think is the best and get on with it. We can continue to research it to make sure that it is having the impact it needs to have. Yes, we can continue to research but we know there are adverse outcomes from patients waiting. Do we want some more research to prove that, or do we want to just resolve the problem?

CHAIR - Spoken like a man of action. Thank you very much for your submission. Thank you for your work and for your testimony here today to the committee. Thank you, Simone, for the work that you do and for your comments today. We have to wrap up now.

Before we go, Simone, I need to remind you from what we said today that everything you have said here is covered by parliamentary privilege but when you turn of the webcast, that privilege does not follow you in any comments that you make outside, even if you are just repeating the things you have said here today. Is that clear?

Ms HAIGH - Yes, that is clear.

CHAIR - Thank you both for attending the committee. We really appreciate the work that you do and your efforts to provide so much information to the committee. We will use it in our report and the recommendations that we make on the basis of your evidence.

Ms HAIGH and Mr BRUNING - Thank you.

THE WITNESSES WITHDREW.

The committee suspended at 9.55 a.m.

The Committee resumed at 10.00 a.m.

CHAIR - Good morning, Paul. We've got online Simon Wood, who is in Launceston, Anita Dow, who is sitting in the room with me, and Simon Behrakis, who will be back in a moment. Just before we start, did you read the guide that the committee secretary gave you?

Dr SCOTT - I did. Yes.

CHAIR - Good. I want to go through a couple of important points. This committee is a proceeding of parliament and, to make sure that we can do the work that we need to do, everything you say today is covered by parliamentary privilege. That means you've got the legal protection to give evidence with freedom from any fear of being sued or questioned in court or another place outside of parliament. You just need to be aware that the protection doesn't follow you when you leave after this committee finishes. When you go outside the door, you're not covered by that parliamentary privilege. This is also a public hearing and people from the community and members of the media might be listening, and your evidence will be recorded. If you want any evidence that you give today to be heard in private, you can ask the committee and we can organise to go in camera. Is that all clear?

Dr SCOTT - Yes. Understood.

Dr PAUL SCOTT, DIRECTOR, ROYAL HOBART HOSPITAL EMERGENCY DEPARTMENT, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks, Paul. Would you like to make an opening statement or comments?

Dr SCOTT - Thank you for inviting me to submit to this committee. I represent the Royal Hobart Emergency Department and the information presented to you in our submission is based on discussions with the senior medical and nursing leadership from the Royal Hobart Hospital, written in conjunction with the deputy director team at the Royal and also based on discussions statewide with the other emergency department directors.

CHAIR - Thank you. Can you tell us how long you've been in your role and how long you've been working in the profession?

Dr SCOTT - I'm currently the acting Director at the Royal Hobart Emergency Department. I've been acting in that role for 17 months now and I've been a specialist medical practitioner working at the Royal since 2016 and a qualified medical practitioner since 2007, based primarily at the Royal Hobart Hospital.

CHAIR - Thanks. Would you like to talk to us about how you've seen things change in the time that you've been there in the Emergency Department?

Dr SCOTT - Certainly. My presence in emergency dates back to the old department based on Argyle Street, then into the new department in, I think, 2007. I can talk to numbers. In 2010 we were seeing 45 000 patients a year, and now we're seeing in excess of 75 000 patients a year, a significant increase in patient presentations. With that, we think there is an increase in the acuity or illness of the patient population presenting to us. That is in keeping

with an ageing Tasmanian population. We see older people who are sicker, who need lay-down treatment spaces and are more likely to be admitted into hospital.

In addition to the numbers increasing and the illness level in the community increasing, we are also seeing a lack of access to inpatient hospital beds and congestion at the back end of the hospital system. This is what we can call exit block, which is where we're waiting on sub-acute bed spaces, residential aged-care facilities, nursing home beds to get people out of the hospital system. The system has become more blocked over the years and that has made it harder to get patients out of Emergency, meaning the Emergency Department becomes more blocked with patients. Subsequently, that means that the ambulance crews are unable to offload their patients because there is no available space.

CHAIR - In the opening part of your submission you make it very clear that it's a whole-of-hospital flow issue. While this is an ambulance ramping inquiry, we fully understand that the issues we are seeing on the ramp are part of a whole system, a whole hospital process problem. It's not a problem with paramedics or Ambulance Tasmania or Emergency Department. It's clear that there's a whole system issue that we're looking at here.

Today, we're interested in your views and the things that you have suggested in your submission about where the blockages are and your view about what should happen in the short- and medium-term response to that.

Dr SCOTT - Certainly. I might just comment there that my expertise lies in emergency department care. I have worked both in the ambulance setting as a retrieval doctor and on the inpatient wards as a trauma specialist, but very much my expertise is the acute phase of patient presentation and emergency care. I am happy to give my general impression of the problems related to hospital congestion and having patients leave the hospital to other facilities. There are other people who are more expert in those areas, but I am very happy to share my thoughts.

CHAIR - Sure, feel free to give your informed view on anything you want to. Can I turn to the comments you made in your submissions about the moral injury that is occurring for people working in the Emergency Department. You define that as people being unable to provide the optimal care patients need and you describe some of the impacts it has on staff. Can you talk about what it is like working in the Emergency Department for staff at the moment?

Dr SCOTT - Certainly. I might just have a framing statement, if I may.

Of the 75 000 patients that present to the Emergency Department, we admit roughly 30 000 of them. Of that 30 000, 10 000 go to our short stay unit that is controlled entirely by the Emergency Department staff and 20 000 go to the inpatient wards. That leaves 45 000 patients a year that the ED staff see, assess and discharge home. That leaves 10 000 we process in the short stay unit and 20 000 that we rely on the inpatient teams' hospital bed stock and efficient processes through the hospital to manage.

From a service provision perspective, we are near the national KPI's in terms of patients seen and discharged in time to home and near or at the KPI's for patients seen and admitted to the short stay unit. These are patient sub-groups we can control as Emergency Department staff.

There is then a large number of patients that we have very little control on and rely on an inpatient bed in the hospital system more generally. This, for example, may be an elderly person who has pneumonia, who we know will need a six- or seven-day admission to the main part of the hospital to get better, have some antibiotics, perhaps some allied health input to get them back up to speed and get them home. Those patients end up - because there are not available beds in the main part of the hospital - staying in ED.

I have 27 acute bed spaces to manage lay-down patients in the Emergency Department. Almost every morning we have 20 to 30 admitted inpatients occupying those 27 bed spaces. On a good day, perhaps if we have 24 admitted patients, I have three lay-down bed spaces in the Emergency Department to deal with 209 admissions which I have on average through the day, knowing very well that 40 per cent of them are going to be admitted.

That then means that my staff, coming back to your question, are unable to deliver the standard of care they know the patients require. They are seeing people in the waiting room. We are having junior doctors assessing people in chairs, we are having people with embarrassing medical conditions waiting in a common waiting room, we are having people with mental health issues who are in a noisy, busy waiting room. Staff are forced to try to manage these people in non-clinical areas.

This is the same as Launceston General Hospital where there are patients managed for extended periods, perhaps over 24 hours, in non-clinical areas. We know we are not examining them to the standard we wish, we cannot lay them down because there are no beds to lay them down on, we cannot examine them properly, we have older people sleeping on chairs, we have people sleeping on the floor, we have people spending overnight in the Emergency Department not in the bed for more than 24 hours. Particularly vulnerable sub-groups, patients with mental health issues, we know we are very restricted in terms of accessing inpatient bed stock for them. Patients requiring transmission-based precautions, which is a term that we use to refer to patients who have infectious conditions we wish to protect other patients and staff from, need a special type of room up in the hospital to move them to. There are a very limited number of rooms, so these patients stay in a common area in ED, often protected simply by a curtain, or perhaps sit in the waiting room for a long period of time with the very same illness that would warrant a single room and special precautions of the ward.

The other vulnerable group is patients who require a patient safety assistant. It might be someone who's behaviourally challenged or someone - perhaps an elderly person with dementia or delirium - who might need constant reassurance and attention from someone to stop them coming to harm, falling from the bed, such things as that.

The final vulnerable patient cohort is someone who is too sick for the ward, but not sick enough for HTU or ICU. Those patients tend to backlog into the Emergency Department.

CHAIR - Too sick for a ward bed?

Dr SCOTT - Too sick for a ward bed because the nursing staff mix on the ward won't take someone who's too sick, they need a higher level of care with extra training. Their destination is ideally a higher acuity bedspace where the staff have extra training and extra support and extra monitoring. There are very few of those available, very limited training amongst the hospital population more generally to manage those people across the ward and means these patients stay in ED. That's not just adults; that's paediatric patients also.

CHAIR - That sounds like a very confronting workplace to turn up to every single workday.

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

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

CHAIR - On top of that, there is the extra, and relatively recent in the history of the Emergency Department burden of ED staff having to manage patients who are on the ramp, who are unable to be given the proper care they need by paramedics because it's outside their scope of practice. There's a physical distance and a whole extra area and complication of working to patients who are on the ramp.

Dr SCOTT - Correct. There is a difficult interplay in non-clinical area utilisation. Launceston General Hospital, for example, has patients in corridors for greater than 24 hours. They've accessed an old cupboard and removed the shelves and had patients in a cupboard. They've used airlock areas. We use essentially non-clinical areas that are going to be utilised with the rebuild shortly for the bulk of our ramp patients. The sicker patients we keep in the corridor next to our resus area. That then has problems with fire access, egress, congestion corridors, lack of privacy, and lack of a proper place to assess people.

The paramedics do a fantastic job looking after their patients within their scope of practice. However, many patients need extended scope to keep them safe. These are the most vulnerable patients in the entire system: patients who are in the community and are yet to be resourced by an ambulance.

The next most vulnerable subset are patients who are on the ramp and are yet to be properly accessed. From the medical side of things, they've been managed up to the limit of the scope of practice from an ambulance perspective, but these people may need different antibiotics the paramedics can't give. They may need special types of procedures, other things that medical can give and paramedics can't.

Then the next most vulnerable are the patients who have been seen on the ramp by a medical team but are in a non-appropriate location, which is not a clinical space and that might be the ramp. We have a frail, elderly, delirious patient who might be on a ramp from 12 to

14 hours, no natural light, noisy, lights on 24 hours, hustle and bustle, toilets nearby but far from ideal and a real dichotomy of what that same patient would get if they were physically located on the ward where they would have a proper day-night cycle, older person-friendly environment in terms of minimising falls' risk and delirium, and more rigorous attention from a nursing staff perspective for ongoing management of care. That may be a strange thing to say.

My emergency nurses are absolutely amazing, and they are focused on the acute phase of the patient's illness. Essentially, we are trying to sort people, ideally in a well-functioning system, within four hours and then having them go to the ward. The national KPIs have 60 per cent of patients off to the ward within four hours and 90 per cent within eight hours. We sit at about 10 per cent within four hours for patients requiring admission to hospital and around 40 odd per cent for eight hours. If you look at how long it takes us to get 90 per cent of patients requiring admission to the main part of the hospital, instead of 90 per cent within eight hours which is the national target, it takes us 25.5 hours.

CHAIR - Wow. You also say in your submission there's an enormous resource cost being incurred by the Department of Health because of the current way the situation is being managed by the need to use locum doctors, because it's so hard to recruit people to work in that circumstance and to get the staff who are needed because of the turnover of staff. Can you speak to the usage of locums?

Dr SCOTT - The usage of locums is an Australia-wide phenomenon. It is a tool, unfortunately, we have had to rely on in Tasmania with Royal Hobart, perhaps better off than Launceston. It's a multi-factorial problem. For a long period of time, medical staff can get paid considerably more in other states around Australia and they can work in a system that does not suffer the same degree of access block; the same degree of challenges of the environment they work in, so they choose to work elsewhere. For my permanent staff, largely out of COVID-19, but also because of the environment they are required to work in, many of them have elected not to work full-time, so I have a large number of doctors on the books but the vast majority work half-time. That is a strategy seen to be protective to maintain the ability to work in that environment.

When my training doctors move to a different unit - they rotate out to get skills in other areas as part of emergency training - they very often up their full-time equivalency to one from half-time because the environment is more protective to their sanity and they are able to operate in it.

CHAIR - That says a lot.

Dr SCOTT - There is a number of other factors but essentially, I have a large number of doctors on the book. Very few of them work fulltime. I have gaps in my rostering because of other places around Australia being more attractive to work for a variety of reasons. Consequently, to deliver the care to the public, I need to get doctors to treat the patients. This year, particularly and at the back of COVID-19, we've had to use locums extensively. We've had some very aggressive recruitment campaigns and commitment from the Tasmanian Health Service in terms of funding to increase our permanent staff numbers.

I am happy to say for the first time since I took on the role, we're looking much better from the permanent staff perspective from around March - April this year up to our full

establishment of registrar doctors. We're still under from a staff specialist perspective. Taking you back to the previous statement of the increased supervisory burden, the registrars that I have, whilst I am full on my establishment, are generally much more junior than they were four or five years ago. I now have the problem of not having enough doctors who are senior enough to maintain the department at night. Now, I also have the burden that the remaining consultants have increased supervisory risk and burden. You often have a queue of eight or 10 people lining up to talk to the specialist to check patient care, to make sure patients are safe. That can go on for hours and hours.

CHAIR - It sounds like these are important stopgap measures, but in no way will they change the underlying situation. From what you said, there will be a continual drain of expertise and staff because of the pressures of working there if the access flow into the hospital - the bed block - is not managed.

Dr SCOTT - Yes. There is a multitude of excellent initiatives. I think the hospital executive at the Royal and the senior leadership teams at the Royal and at the Department of Health understand the problem. It is not just an ED problem. Having that recognition is an important start and it helps my staff to think there is some light at the end of the tunnel.

Extra staffing: we are looking better from a recruitment perspective and thankfully we are moving forward with an ED rebuild which will increase our beds and other points of care where we can treat people. There are some positive things on the horizon, but the access block needs to be addressed in order to fix the transfer of care delay. If it is not, we will end up with a bigger emergency department that is full.

CHAIR - The minister has said that 40 per cent of emergency department attendees are non-urgent and people who should be seeing a GP. As you would be aware, and as you have commented in your submission, the idea is proposed that urgent care centres will be an amelioration of the current situation. From the data that you have just provided, do you think that there is a relationship between the urgent care centres and more community care and the 20 000 patients per year that need to have a bed, an inpatient ward? Or are they the 45 000 who are processed by emergency departments on an annual basis?

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

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

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

CHAIR - What happens when patients come in by ambulance? As we have heard from other people at the hearings, people are now being forced to call ambulances because there is no other community health available, particularly in their regional area. Then they end up on the ramp for non-admitting reasons. Are they quickly triaged to get them off the ramp? It seems as though there is a process problem there in being able to have the resources to move that triage process through quickly so that people who are on the ramp are not necessarily people who need to be admitted to hospital.

Dr SCOTT - You have heard differing opinions on this. My opinion is that the ambulance service is very good at recognising people who don't need a lay-down bed space, hence to stay on an ambulance stretcher or be in a bed. Subsequently, they are offloaded into the waiting room and they go into the standard queue for a patient who doesn't need a bed.

There are processes that ambulance are initiating now which allows automatic transfer from ambulance stretcher into the waiting room without even experiencing transfer of care delay or what we colloquially call 'ramping', so that's not my impression. The people who end up on the ramp are people who perhaps have had a fall; they have hip pain, concern perhaps they have a fractured hip and they're not appropriate to be offloaded from a lay-down stretcher or bed to the waiting room. So, transfer of care - ramping, if you like - is entirely patients who aren't safe to be put in the waiting room or almost entirely, in my opinion.

CHAIR - Thank you. Anita?

Ms DOW - Thank you for presenting to our committee and thank you for the work that you do, because it can't be easy. I wanted to draw your attention to where you talk about short-term and medium-term interventions that could be undertaken immediately. You talk about clear escalation policies. Could you please provide more details to the committee about what they would look like?

Dr SCOTT - Again, complex questions. None of them have easy answers. A problem we have in the health system is the patient tracking systems that Ambulance use don't talk cleanly to the emergency department systems and they don't talk cleanly to the inpatient systems that allow patient transfer through the hospital system. The reason for that is, I guess, that a non-integrated approach was taken to look at the data system managements that the various aspects of the pre-hospital and hospital environments use and that has meant that they don't integrate very well.

However, there is enough sophistication in those systems to predict the type of load that we will experience in the ED on a daily basis and that the hospital will experience in terms of the number of patients requiring admission. We can also predict other factors like the length of stay that a general patient cohort may need. We're looking at short to medium-term fixes, having information systems that can predict the number of patients that will actually present the next day as well as real-time feeds in terms of activity. If I know there are seven ambulances half an hour away from the emergency department, I need to know that they're coming in and I need to create immediate space and be able to escalate and clear space out of ED, ideally to move patients up to the ward to be able to accommodate those ambulances.

At the moment, we don't do that. Not only is there predictive data that we can look 48 hours ahead with very good accuracy to work out how many patients are going to attend the

emergency department, but also the very short-term predictive power which is, 'hey, I'm about to get five ambulances in the next 20 minutes', we don't clearly capture. That makes it very difficult when we suddenly have to find four or five lay-down spaces, perhaps in a car accident in Tea Tree within a short period of time. Hopefully that answers your question.

Ms DOW - It does. Thank you. The other thing that I wanted to ask you about was a cultural change to a seven-day-a-week health system. This has been mentioned a number of times during our committee proceedings and the importance of having access to radiology, pathology, and pharmacy 24 hours a day. I wondered if you might put some further comments on the record about your thoughts on it. How would it improve the flow of the hospital and the ability to get patients back out, discharged into the community?

Dr SCOTT - Since writing this submission, there's been some excellent work in the medical leadership space at the Royal Hobart Hospital and they have actually proposed a seven-day-a-week medical admissions team that would be based in the emergency department. They fully recognise the Royal Hobart is now big enough to no longer be a Monday to Friday model, 8.00-5.00. It is now a hospital that requires a 24-hour level of service.

Just as the medical workforce is strained in terms of finding people willing to work for less money and worse conditions, that is true right across the board, from pharmacy to allied health, radiographers, pathology staff, other allied Health staff, clerical staff, support staff. There is a lack of resourcing, generally, to be able to run services 24 hours a day.

So, what would be regarded as a routine care episode for a patient, such as getting an ultrasound for perhaps a pathology that you want to protect them from doing a CT on - perhaps a young lady who is pregnant - that is not easily available; you have to call people in from home. That may impact the next day's roster and is certainly not available after hours in any reliable way. Yet we have people turning up throughout the day, every day, seven days a week, more so on public holidays and long holiday periods. There is a mismatch in availability of resources and staffing to support a seven-day-a-week function.

CHAIR - When you say availability of resources, do you mean money to support paying staff the extra loading to work late at night?

Dr SCOTT - I think it is mixed. There is money available to recruit people. We have trouble recruiting because of the things I have talked about. When I say resources, I guess I speak more generally such as ultrasound or having more staff on at night to handle the increased load and busy-ness in the pathology lab or more orderlies, more other people.

CHAIR - Diagnostic imaging?

Dr SCOTT - Yes. There have been improvements in that space. People are working hard; we have made some significant improvements in the radiology space with doctors on overnight now several days a week.

CHAIR - This is recently?

Dr SCOTT - Yes, recently. There is definitely work done recently which has made a huge difference and will continue to. We are still under resourced, it is still more a five-day-a-week model.

CHAIR - To your understanding, would that just be happening in the Royal, not at the LGH and the North West?

Dr SCOTT - The under resourcing?

CHAIR - This change to the 24-hour-a-day model.

Dr SCOTT - It is interesting. We meet weekly with the other directors of the emergency department around the state, and it is fascinating to see how they have solved similar problems. There is no consistency on a statewide level for significant problems. That might be how we manage a sick leave roster or how we call people back in at short notice, things like that. They have adopted their own approach which has been locally endorsed or approved; we've got our own approach. From an overall statewide governance resourcing consistency-of-practice approach, in my opinion there's some work to do in that space.

Ms DOW - So, what you are saying is that there should be a statewide approach to that?

Dr SCOTT - I think that in many areas, obviously there will be local variations and you need the local commissions to make sure that statewide policies are appropriately structured to their needs. But statewide clarification on sharing of risk across the hospital system, covering sick leave, short-notice callback for shifts, whether or not we can pay short-notice locums or we can actually call our own staff back to cover sick leave - all of these things could be simply addressed, I think, at a statewide level for consistency.

Mr BEHRAKIS - Touching back on the moving away from the sort of nine-to-five, five-day-a-week model, correct me if I have misunderstood anything but you said that there are resources to recruit, but there is difficulty in recruiting because people do not want to work in such a strained health system. Having the staff to move away from a five-day-a-week model would reduce that strain. It seems like we have a bit of a Catch-22, where recruiting people into that system would reduce that strain, but we can't recruit people into it because of the strain. How do we get over that hurdle to get that ball rolling in the first place?

Dr SCOTT - This committee is a good start. Seriously, having senior government-level recognition that this is a big problem, and healthcare in general, is a big problem, as well as THS and Department of Health level support, which we do at the moment, and senior leadership support within the hospital recognising there is a problem. The risk is - and I don't mean offence by this, we have had, I think, , 12 Emergency Department reviews in 15 years. We go to all this trouble to have excellent reviews but we don't have the back end on it to actually enact recommendations and hold people to account with the recommendations.

So, how do you go about it? I think a centre that looks at new initiatives and has funding to short-term trial new initiatives, has the proper data and IT support to actually look at whether the initiative is effective. If it is and it is cost-saving and better for patients, then you can roll it out as a bigger program. So, a centre of clinical innovation or something like that would be helpful. I think if potential staff see that things are being done in that space, they are more likely to come to Tasmania.

The recent EBA changes across the nursing and medical workforce, as well as some allied health changes and ambulance changes, will help but it's sort of a leapfrogging thing. We've matched Victoria. Victoria's going to go up next year or the year after, so they poach

people back off us. There's this constant leapfrogging of trying to make things more attractive. Salary alone doesn't do it. It's work conditions. It is, I think, the vision that the senior management are holding staff to account and keen to improve on efficiencies and processes to actually make care better for patients.

CHAIR - We don't have a lot of time and I want to get to the other comments that you make in your submission about the rest of the hospital and the bed block from ED which is stopping those 20 000 patients a year being exited from ED in a timely fashion. That would flow on to preventing the ambulance ramping in the form that is, so it all leads together.

You've mentioned at one point that there is a flow-on effect for patients. I think you talked about when there are short-term protocols that an activation of a process which transfers automatically, because when there's a pinch point, it'll transfer eight to 10 people out of the Emergency Department into wards at short notice. Then they would remain the responsibility of the wards, and the nursing staff and medical professionals on the ward. Sometimes they would be sitting in corridors on the wards. But then you said it has the perverse effect where, when that finishes, the wards won't receive any new patients because they are full at their end, so it doesn't actually help. It's a short-term sugar fix but it doesn't help with the ongoing reality of people who are still coming into the Emergency Department.

What do you think of the view that moving the pressure to the wards would be helpful in terms of making the system changes we need? At the moment the pressure on the Emergency Department and the ramp is intolerable and is causing burnout. To be able to move those patients to areas where they are, overall, having access to at least a bed of some sort, at least the medical and nursing staff that are not available in the emergency departments. It would likely require an increase in resourcing, of course, and dealing with the discharge problems at the other end.

Dr SCOTT - Again, a very complex question. I will approach this in a couple of ways. If you look at the risk to the patient, the greatest risk, as mentioned, is the unresourced emergency job in the community. The next greatest risky place is in the Emergency Department. If we look at sharing the risk across the organisation, then having some patients go to the ward and temporarily be in an over-census space while the ward waits for a planned discharge to vacate a bed on the ward, that, from an Emergency Department perspective, is more than reasonable. If you look at me, I have more than a ward of admitted inpatients in my Emergency Department 24/7 every day, plus dealing with 220 new arrivals. I'm asking a ward to go over census by one or two patients. That will be an enormous change in practice to ward-based staff, who do an absolutely fabulous job and advocate for their patients extremely strongly that they should get the appropriate kind of care to let them get better. If you're putting people in the corridor on the ward, that is not the standard of care that helps people heal, but if we look at an organisation perspective, they would perhaps need to do that and tolerate spreading the risk.

CHAIR - Can I just clarify, sorry to interrupt, are you saying for the patient risk point of view, the lowest risk overall would be if they were in the ward?

Dr SCOTT - It is the patient who has been worked up by ED, has had immediate life-saving treatment made, most of the time a diagnosis made with appropriate treatment commenced and the patient is in the healing phase of the acute phase of the illness, rather than the actual undifferentiated super-acute phase of their illness in ED. These patients are safer,

they are much safer than a ramped patient who hasn't had medical assessment, who is in a non-clinical space in the dark around the corner.

I will put someone who I've got appropriate treatment going for, they've got appropriative conclusion criteria in terms of their observations are normal, they don't need a patient safety assistant, they don't have infectious disease, they're not a falls risk, they will go in the corridor. That for me is the sharing of risk across an organisation and that's the seven-day. Suddenly the Royal is big, right. In my opinion, the wards absolutely do an amazing job and the care they deliver is what patients need to get better, but we're at the stage where we probably do need to share that risk across the place.

Actually, just loading up the wards isn't going to fix the problem. It's actually the exit block, getting people out of the hospital, getting them into residential aged care, looking at the patients who no longer need an acute care space. This may be complex patients who need social support, might be a homeless patient we're trying to get out into the community and keep safe. It might be someone who is requiring NDIS assessment. We know that takes three to four weeks to be completed and then they might come back and say, 'We're only partially funding the care episode'. Then we have to re-enter the cycle while they're still in an acute hospital bed and look at how we're going to manage that other part the NDIS couldn't do.

It might be residential aged-care facility people where often we have 20 people waiting for residential aged care, but perhaps only 10 of them are actually ready for residential aged care, nursing home placement. The other 10 need guardianship assessment or ACAT (Aged Care Assessment Team) assessment or other things. It's an over-simplification to say, 'Well, there are 20 nursing home patients we can get out straightaway'. There's probably less than half of that and some of them are relying on processes that are beyond our control in terms of getting it done in a timely manner. We have some patients who spend hundreds of days in hospital. I've actually got one patient at the moment who has spent more than a year in an acute hospital bed in the Royal because of lack of ability to get people out into the community safely with the care they need.

CHAIR - Would you support having a hard time limit on people being in emergency departments? The national standards, as you have said, do have national standards. I understand that Ambulance Tasmania, HACSU were discussing a minimum and mandated time on the ramp. Would you see that it would help the system overall if there was a minimum and mandated time in emergency? Are other states going down that?

Dr SCOTT - There are nationally recommended KPIs in terms of percentage out of ED within four hours, eight hours, 12 hours sort of thing. That data is already there. It's well supported nationally.

CHAIR - But we don't adhere to them?

Dr SCOTT - We can't adhere to them with the current resourcing. There is probably a lack of some acute hospital bed stock. Already we purchase beds in private facilities. You could give me another 35, 40 beds and bang, I've fixed access block probably for a couple of months. Without fixing exit block of getting people out of hospital, it's just going to recur in a couple of months.

Do I support mandated transfer to the ward within a certain time period? Perhaps, for the right patient, but we don't want to do harm to patients. We don't want to send the wrong patient upstairs who is perhaps still in a vulnerable state in terms of their illness and needs appropriate monitoring. If I am sending him into the corridor or up in the ward, that's going to do harm. It's going to have the back end of moral injury to staff on the ward, complaints, safety events - all sorts of things - if we send the wrong people.

Mandating a discharge out of ED is dangerous. On the other hand, particularly with HACSU's motion to have ambulances offload their patients within 30 minutes, which will probably become live in April or June this year, and ambulance crews clear within 60 minutes, we need something. Otherwise, EDs are going to absorb those patients. I know in winter after 4 o'clock to midnight I have between seven and nine ambulances every hour - it might be the same patient - per hour every day waiting for somewhere to go. I can't absorb with my current resourcing and space; I need the rest of the hospital. Also, I need community and outpatient community services and outpatient allied health, and residential aged care and NDIS, and all sorts of things to talk more cleanly to each other.

Coordinating outpatient exit block care - having a single centre that would look at all the allied health needs, where the resourcing is and who could provide the services that patients need - is probably a medium to long-term fix which would actually stop the inpatient team doing the physio stuff; the rehab guys doing the physio stuff; the community-based physio doing the physio stuff. At different phases in the patient's journey we can get efficiencies and processing like that but, again, I am not an expert in this area; I'm an ED doc and that's what I see and I could be wrong.

CHAIR - Sure.

Ms DOW - In your submission to this committee, you refer to the fact on the current working group looking at that transfer-of-care delay work with the health unions and Ambulance Tasmania, that there isn't staff on the Emergency Department involved in that working group. You have put there quite clearly you'd like to see that happen. I wanted to offer you the opportunity to put some further remarks regarding that on the record for the committee.

Dr SCOTT - Thank you. Again, since the submission of that document after some vigorous discussion, it was agreed that emergency, nursing, medical staff, hospital senior staff and access and flow staff should be consulted before this policy is enacted. We are in a bit of a difficult position because it takes many months to change culture and systems and processes. HACSU is expecting an outcome in April or June. I do not think Australian Nursing and Midwifery Federation and the Australian Medical Association are. Certainly, from an internal perspective, patients are going to be harmed if the ambos are leaving patients in an environment where we are unable to take over the care in an appropriate way. At the moment I can't, because I can't get access to them so I need the hospital to absorb people and for the hospital to absorb people. It needs to be able to get people out.

Ms DOW - Thank you.

CHAIR - Paul, we've been hearing there's an increase in the number of people who are very unwell who are being ramped - Category 2 patients. Is that what you have been seeing?

Dr SCOTT - Yes, interesting, there is a general increase in what we call Category 2 patients. They are patients who in an ideal system should be seen or have a meaningful intervention within 10 minutes of arrival. If we look at the data on that, we have had an overall increase in the illness of the patients. Some of that is probably explained by the general ageing of the population. We know as people become older, they have more visits to the Emergency Department, more visits to their GP and they end up more unwell. Some of it's difficult to explain. Some of it may be the public expectation they get seen more quickly if they call an ambulance, rather than self-present to emergency.

There is a risk with that. If I have these emergency offload systems you've mentioned before and I offload ambulance patients into beds, I might have someone who has chosen not to call an ambulance and perhaps is having a heart attack who has walked into the waiting room and is just as sick as the person on the ambulance trolley, but because of the preferential offload of the ambulance trolley, there is a dichotomy of care.

Basically, I am providing a different level of care to the same type of patient with the same condition. These are complex issues and without having an overall increase in available points of care and space in ED, we're forced to provide different levels of care to the same pathology, which again is a moral injury to staff because we know that the older person asleep on the waiting room chairs for the last nine hours needs a bed.

CHAIR - Yet, we know from the data that was provided to the committee by the Tasmanian Health Service that 136 people have died over the last five-year period of recording after being on extended periods on the ramp and within one day of being in hospital. The data from other jurisdictions is very clear that there is a relationship between extended ramping periods and an increased risk of death and adverse outcomes. The minister who responded to this, Jo Palmer, minister for Primary Industries, said that there was no relationship between these data and people being on the ambulance ramp. Do you have a comment about that?

Dr SCOTT - Data is tricky. I appreciate your background, actually. You would know this better than I do. I would like to see that data. I do not know how many people have come in with an acute illness, who have not been ramped, who have also passed away in that same time period. You would need to match: is it an ambulance thing? Is it a walk-in? Is it a ramping? Is it not? Is it just the disease? I cannot really comment on your specific question.

However, I can infer from data that is well known in the emergency/medicine space that there is increased mortality to patients in ED when there is access block. By inference, that would mean that if patients are ramped for an extended period and experience access block, then mortality does go up. However, I cannot specifically comment on the data you have suggested.

CHAIR - The data show that over the last five years - within the last year - 44 deaths occurred out of 136. There has been a steep increase in the number of deaths over that period which does mirror the extended period of time on the ramp. You are right: without a comprehensive study we can't be specific about individual instances. However, would you agree that given the overall research in the area showing that relationship that does seem to suggest that the increase in people on the ramp and the length of time is leading to avoidable and earlier deaths?

Dr SCOTT - I believe that there is evidence to say that when patients experience access block, their mortality goes up and there are unavoidable deaths unfortunately associated with that. Now, if you want to say that it is a combination of ambulance transfer-of-care delay and access block, then that would follow that there is increased harm to patients unfortunately sometimes causing death because of delay to get them to inpatient ward.

CHAIR - We do know enough to take action. I am also interested whether we have data that is collected about the length of time that people are waiting as walk-ins in the ED waiting room. You were speaking about the difference and being able to attend. We have two different streams coming in. Do we have the information about how long people are waiting as walk-ins?

Dr SCOTT - We do capture those information points. There are some things that are very difficult to capture. We have some fantastic people doing the best they can in the data and health analytics space. However, the nature of the programs we have bought to track patient flow is such that it is very difficult to generate the types of reports we need with the clarity on specific questions such as you have just given me. It requires often complex manual entry of times, reviewing of Excel spreadsheeting, individual collation of data. There are some automated data triggers and people are doing a good job in that space. For a lot of the specific questions like that, I would have to get someone who is IT savvy. Luckily, I have a couple of doctors who are IT savvy and a couple of nurses and do that. Basically, we need better health systems analyst data managers. We need real-time data, performance data that is displayed real time, right across the hospital. The THS and the DOH - I believe - in terms of performance metrics to actually tell what is going on. We have work in that space to do.

CHAIR - We went to the LGH Emergency Department and had a look and there are a lot of bells and whistles and screens and information coming in. Your evidence details a whole range of different data information systems, Track IPM, Medtasker - which it seems are fragmented and do not talk to each other and Ambulance Tasmania information certainly is not talking properly into the rest of the health system to get that information. The systems need to talk to each other, is what your submission says. What needs to be done? Do we need all these systems? Is it a case of replacing them, or is it really just about the will to prioritise doing that work?

Dr SCOTT - There is a larger - I think it is called e-health reform - and there is a larger project that is occurring, which I think is in the tender phase at the moment, for large providers to actually look at the healthcare more globally. I do not from my understanding think that will include an ambulance module-

CHAIR - Have you been consulted about that?

Dr SCOTT - Yes, there has been some consultation and thankfully we have an ED specialist on that group as well so there has been good sort of cross system input in terms of what we need. I think we need to be careful that it does talk to ambulance and gets not only a short-term proactive feed of ambulance arrivals but also expected activity feeds from other things and they all talk to each other and generate things. It is probably still a few years away, so, we are doing-

CHAIR - To get a tender?

Dr SCOTT - No, sorry, to roll the project out. The vision, as I understand it but again not expert, is to have it deal with the hospital system more generally. So, in-patients, ED but also community-based referrals if you need to follow up on other things. So, it sounds like a promising move in the right direction. It is still quite a while away. In the meantime, we are stuck with trying to do ad hoc patches, I guess, to try to have the ambulance feeds talk to the track feeds. We have IT people working on that but it is complicated because the systems are not clean in how they interact.

Ms DOW - Can you just clarify, I think before you said that there was not going to be an Ambulance Tasmania component to that?

Dr SCOTT - Again, not expert. You are better off talking to someone in e-Health area.

CHAIR - Do you think it should speak to aged-care facilities as well?

Dr SCOTT - It is complex with funding models and there is some Commonwealth funding for certain areas and state funding for others, and I am sure there are layers of complexity there. I think having a single system that is visible to people to see what sort of referrals and outpatient care hospital avoidance and ongoing care after people leave hospital is available just makes sense. It is a holistic approach to the patient journey, which starts with calling an ambulance perhaps but might end five months down the track after a rehab bed placement and reconditioning, getting back to home with some services. It just makes sense to see it all on the one-patient journey in my opinion.

Mr BEHRAKIS - Forgive me if I am asking questions outside of your expertise. On this data management/data systems talking to each other, I would not have thought that Tasmanian Health System is particularly unique compared to other cities or other jurisdictions around the world as far as what its needs are as talking to ambulance services and other health services. Is there not a product for this? Or is this something that is being sort of custom made everywhere around the world? There are hospitals everywhere. I would have thought this would be something that you can just buy a product and they are all set to talk to each other. It would kind of be expected that these sort of systems would be intended to be able to speak to each other. It is curious to me that it is not an obvious thing.

Dr SCOTT - You are right. There are many health solutions. It depends how much you want to pay. The decision was made several years ago to buy a particular system, I think, because it was probably cheaper, to be frank. We have inherited the problems with that and the lack of integration with other systems. So, you can buy something off the shelf that deals with the whole health solution. It just depends how much you want to pay. We have elected for something that was cheaper and we are really feeling the pain from that many years down the track.

Mr BEHRAKIS - When was that?

Dr SCOTT - Probably eight-plus years.

CHAIR - I think we need to wrap up now. Thank you. Is there anything else you wanted to say before we finish? Is there anything else that you want to propose? You've already listed short-, medium- and long-term solutions and we've talked through a number of them. Is there anything that you want to add?

Dr SCOTT - Thank you for having me. If anything, it's fantastic that you're doing the review in the detail you are. I don't want it to go the way of all these other reviews we've done, which is making fantastic recommendations but not resourcing the back end to actually enact change. If anything, if you're able to suggest that there is proper resourcing, proper governance, proper IT systems and data management and performance indicator tracking out the back end of this forever, not just for a year, it's a long-term problem. Your recommendations will be welcome but without having a system to put them into place and additional resourcing, not for something to come off the side desk of already busy people - it's having extra people that will make this work - that would be my main focus in making things better for the Tasmanian public.

CHAIR - Thank you. In all likelihood we would make recommendations in that area and then it's up to the Government to implement them. Obviously, members here will be doing everything we can in an ongoing way to hold whatever government to account to make sure that there is the resourcing - and the solutions are put into place.

I want to ask you about the seven-day-a-week move to the medical model you mentioned, which is great, that recent change. Has that come with additional resourcing, or is that taking it out of the -

Dr SCOTT - It's a proposed change at the moment that is going in front of the executive I think this week, with a view to rolling it out in February. They are recruiting for some additional resourcing. I've been invited to sit on the physician panel, which is fantastic. We're starting to see recognition that it's a whole-of-system thing now so rather than just having sub-specialty doctors interviewing sub-specialty doctors it's more of a whole-of-system approach, which is refreshing to see and fantastic. That's a good initiative that's not quite yet enacted.

CHAIR - Right. Do you know if it's a separate and additional budget resourcing that will go into that?

Dr SCOTT - I believe that - again, I might be wrong - but I believe the FTE funding was available already but difficulty in recruiting.

CHAIR - Okay. Thank you very much, Dr Scott. Before we commenced, I reminded you about the fact that what you said today is being covered by parliamentary privilege, but when you leave here anything that you say is not covered by parliamentary privilege, even if you're referring to things that you said here before us today. Do you understand?

Dr SCOTT - I do. Understood.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.

The Committee suspended at 11.03 a.m.

The Committee resumed at 12.00 p.m.

Ms ROBYN HENDRY, GENERAL MANAGER, **Dr PAUL DUGDALE**, PRINCIPLE MEDICAL ADVISOR, ASPEN MEDICAL ADVISORY SERVICES, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Before we start, can I ask, Paul, whether you have read the information provided by the secretary?

Dr DUGDALE - Yes.

CHAIR - Good. I want to reiterate a couple of important aspects of that. First, this is a committee which is a proceeding of parliament, so you receive parliamentary privilege in the things you say here today. It's a legal protection that gives you the privilege of being able to speak freely and not fear defamation or other court proceedings. It also means that the protection doesn't stay with you when you leave the committee, even if you might repeat some of the things you said in here. That privilege doesn't follow you outside but it's here with you today so that you can speak frankly on any matter that you want to us. Today's proceedings are being webcast, they are being made available to the public and there might be members of the community and journalists watching the proceedings. Is that clear?

Dr DUGDALE - Yes, thank you.

CHAIR - Robyn, is that clear to you, too?

Ms HENDRY - Yes, it is, thanks, Dr Woodruff.

CHAIR - Do you have an opening statement? We have your evidence, and we have all received and read that. We have Anita Dow, Simon Behrakis and, online, in the north of the state in Launceston, are Simon Wood and Michelle O'Byrne, who are other members of the committee.

Ms HENDRY - Chair, we would like to make an opening statement with the committee's agreement. I'd like to make that statement at the right time.

CHAIR - Go ahead.

Ms HENDRY - Thanks for the invitation to make an opening statement. We provide this statement to provide context to our submission. Aspen Medical is an Australian-owned and headquartered company that provides specialist healthcare advice and access to a broad network of experts to support and inform clients' planning decisions, their delivery of healthcare and other associated decisions. We are a global provider of innovative healthcare solutions for a diverse range of clients in government, global agencies, non-government organisations and the private sector, operating in 21 countries around the world. Over the last 20 years we have become a world leader in the delivery of healthcare solutions in any setting, particularly those that are remote, challenging or under resourced.

You will have received our written submission in October, and you have our ambulance ramping issues paper published on our website in September 2022. We are interested in ambulance ramping as a critical issue in the operation of Australia's state and territory health

systems for several reasons. Firstly, we own and operate a fleet of air ambulances in Queensland and Western Australia, servicing both the public sector and private companies. We also have several overseas business interests in road ambulance services. This gives us an experience-based understanding of the interconnections between ambulance services and other parts of the health system. Secondly, during the latter part of the COVID-19 national emergency, each of our Australian state-based officers reported local concerns with issues in public hospital emergency departments; recipients of patients brought in by ambulance. Although each state had a different set of circumstances, it was clear that there was a national problem.

In response to this national problem, we held several internal discussions and prepared some material analysing the issues and identifying where and how we might be able to assist. Over the years, Aspen Medical Advisory Services has released several papers, including the Ambulance Ramping Issues Paper in September 2022, which are of contribution to the public debate. The Ambulance Ramping Issues Paper identified several opportunities for lasting change, naturally, including some in which we thought Aspen Medical could play a part. We were pleased to receive an invitation to make a submission to this committee. The submission provides a brief review of the Tasmanian experience and some innovations from other jurisdictions, both nationally and internationally.

We thought it would be interesting for Tasmania and offer several specific suggestions for reform. Committee members have our paper and our submission and therefore we will not read from it now in these opening remarks, although, of course, we are happy to discuss any matters in them you wish to follow up.

We would, however, like to make two general points now. Firstly, ambulance ramping is a highly visible problem with a complex set of causes. Some of these causes are not obvious and some are solutions to other problems that have created unintended consequences. Solving this type of problem requires a careful analysis: innovation involving several disparate parts of the system, review of potential consequential outcomes and a spirit of collaboration. This is clearly implicit in the terms of reference of the select committee.

Secondly and in the same spirit, we suggest the committee consider what could be learnt from the private sector and how it might contribute to reforms and improvements to the health system to reduce ambulance ramping. Private sector business constitutes a large and vigorous part of the Australian health sector. With the right modes of engagement, it can network into and mesh well with the public sector. We think this could be the case, too, for solutions for ambulance ramping.

Thank you again for the opportunity to participant in the hearing today.

CHAIR - Thank you, Robyn. I will address my question to whoever you think is best able to answer, Robyn or Paul. I have read, and maybe we will just move to some of the solutions you have been proposing in your paper, which we would like to drill down into a bit more. The suggestion number two is important. Which is, a system audit to identify short-, medium- and long-term implementation options to address ambulance ramping and associated issues at local, regional and national level. Are you aware that Tasmania has had - at least the Royal Hobart Hospital, if not all hospitals - 12 emergency department reviews of management and other issues? What are your views about how to best manage a failure of implementation

and coordination, connecting in with other parts of the health system, which appears to be happening.

Dr DUGDALE - A great question for a committee that is going to produce another set of recommendations.

CHAIR - Exactly, it wears on my mind.

Dr DUGDALE - It is a crucial part of any investigation to have an implementation. I was, in preparation for coming today, reading the independent review of Tasmanian EDs which has just come out and their interim recommendations. They went through the history of other reviews from - I think - 2009. They also mentioned the Auditor-General's review a few years ago of all the outstanding recommendations. It was good to see that they were, at least, enumerating all the recommendations and forensically seeing whether they have been investigated or not, and I know that's an interest for the committee.

CHAIR - That's very important work.

Dr DUGDALE - It seems like a lot of inquiries into ED, and I think that is possible because it's a small jurisdiction, and we have a similar thing in the ACT. In the larger states, there are always these inquiries and audits going on at local health district level. They don't get the same prominence at state level that they can in a small jurisdiction. That might be good. These matters are of great interest to the public. Maybe it's democracy in action that you see public inquiries in a small jurisdiction that are just private local health district inquiries in a larger jurisdiction and there is a stack of them, because their hospitals have the same problems.

In terms of tracking implementation, those quieter, non-public inquiries often have good implementation methodology built in in the local health district system. There are a lot of counter examples and, the closer you are to the problem, the more you should be able to sustain that implementation, but I would say that it's a hard one.

CHAIR - Does Aspen have a view, given the work that you do in Australia in other jurisdictions, and as you said, Robyn, finding similar issues in other states - we are aware of that - have you found or have you anything to say to us about the differences of what is happening in Tasmania?

Ms HENDRY - I might just make a general statement, if I may, regarding our experience then throw back to Paul in the granular. It's our experience that audits are often not as broad as one might wish for because they look at parts of the system and not necessarily the interrelationships between the system. It's our experience generally in dealing with clients that we've found interesting insights and correlations by broadening the scope of those audits and seeing where there are opportunities. We take the view that if you keep doing the same, of course you get the same. Whilst every system and every component of the system can see and aspire to improve, they can see opportunities for improvement, but we think that the integration of the broader system is perhaps where the most opportunity lies. I will throw back to Paul now, if I may, to expand on that.

CHAIR - Thanks. That's an important point.

Dr DUGDALE - I think a good analogy is in diagnosing a chronic condition in a patient. There is not a single cause. There are multiple factors that come together to produce a particular set of signs. In each state and territory where they're having ambulance ramping problems, they have different issues. Workforce is one, ED staffing, and very long stay patients in the hospital is a particular problem in Tasmania that is much less in other jurisdictions where they have more aged care options. On the other hand, the problems of the big cities can be unique as well and Hobart doesn't have the problems of Melbourne or Sydney.

In terms of the solutions, though, if you can get data and tracking of each of those different problems, you can have a particular solution in your area and the solutions will move because the problem will move around. We met this morning with your Hospital in the Home and geriatric evaluation and management at home and community rapid response service team. They're great and you're better served by that part of the service than most of the rest of the states. On the other hand, you haven't got an integrated digital health record yet in Tasmania so that's going to be a priority. You've got some good things and some things where you're a bit behind Melbourne or Sydney.

CHAIR - What about the data integration that you've mentioned? We've had evidence about the multiple different software and data collection parts of the system, at least four in the hospitals; and the inability at the moment for Ambulance Tasmania information to nest into that and to be compatible; that there isn't the patient flow across the system information as well as information about the patient needs at each point in the system. Are you aware of other states where that happens and happens well?

Dr DUGDALE - Not specifically. In the ACT, we're just in the process of implementing a digital health record across both hospitals and the ambulance service has previously been able to have a view into the EDIS system (Emergency Department Information System). I don't know if they have it here. I think treating the ambulance service - their dispatch centre, their paramedics on the road, and they generally have a clinical support line that the paramedics can call - treating them as fully integral with the health system. Those staff having access to public hospital records, I understand, talking to the doctors this morning, that the paramedic clinical support people can see pathology from your main public hospital system here, which is quite useful for a lot of their patients, but they can't see the hospital admission record.

CHAIR - So the clinical supports for paramedics? You're saying not individual paramedics but the clinical support can see that pathology information?

Dr DUGDALE - Yes, so the paramedic can call from the home, call their clinical support line that they've got access to some data. I haven't come to tell you how the Tasmanian health system works. I'm not particularly familiar with it. I think Australia-wide and worldwide we're in a process of evolution of better integration of data. Ten years ago, we had large amounts of data digitalised in electronic records but we had no liquidity of that data. It was seen as 'we have to get data liquidity' for the people who are caring for people in the system.

I think we have a lot better data liquidity now but we haven't got the integration and the connection of that yet. That's a huge dynamic at the moment in the digitalisation of health. I think the next thing that is coming, as that data can be brought into the one place, is the analysis of it and the understanding of it. It's sort of like 'be careful what you wish for,' with these complex patients. You want to get into the whole of their health record? We've all seen the paper stacks of them back in those days. As a young resident, I remember thinking, 'Oh

my god, how am I going to go through these hundreds of pages?' It is the same with digital data. You have to be able to analyse it. Artificial intelligence and proper digital approaches to rapid analysis of the important things in that data as it is becoming much more liquid and as it's being connected between services is where things are going and it has to be invested in.

Ms HENDRY - To make an additional point, there are two sides of that question. There is the enabling good clinical carers, as Paul has spoken about, and understanding people's history and record and having support for clinicians, but equally there is the prevention of over employment of both ambulance arriving at ED and ED and the data insights that can be drawn from perhaps opportunity to fully utilise other pathways before ED.

I think that is an interesting area that perhaps could warrant some consideration. It was interesting to us that a lot of increased presentations to ED in Tasmania are working-aged people. That does suggest potentially a couple of hypotheses. Of course until you go into the data you do not know but perhaps people are not seeking care earlier or perhaps access to the primary health network is more difficult and so they end up going to ED out of hours.

So, just those sorts of insights - are we over employing ED and ambulances and under employing or at least not exploiting the opportunity for other parts of the system?

CHAIR - Yes, there is certainly evidence that there are, well by the evidence we just received for the Royal Hobart Hospital, 45 000 of 75 000 patients a year are people who are coming in and do not require a bed. So they require treatment of some form or assessment of some form in the Emergency Department and then they leave again. So, that is a burden on the Emergency Department but it is not an issue from a ramping point of view in terms of bed block because they are not going to need a bed. The urgent care centres and a whole range of other more primary healthcare alternatives and options in the community are an issue for us.

I do not know if you had any particular thoughts about the urgent care centre model?

Dr DUGDALE - Can somebody dial 000, have an ambulance dispatched, paramedic think this is a good option for the urgent care centre, discuss it with the patient who then says, 'Yes, take me there'? Is that going to be a pathway within the system and how can that be supported and expedited? Are there other places that the ambulances can take people? Or are there other services that they can get to come to the home? That is all part of the expansion of what ambulances and paramedics do that is in part based on their growing confidence as a profession and they have shipped to -

CHAIR - Community paramedics?

Dr DUGDALE - Yes, ambulance paramedics, who these days are often being trained at university degree level. They are now registered with AHPRA (Australian Health Practitioner Regulation Agency). They are growing in confidence. I think the idea that their job is just to transport to the ED has to be expanded to ask, 'What's in the patient's best interests? In fact, I am going to discuss this with the patient, see what they think, maybe talk to other people in the family or other carers and arrange what is best for them', which is often not the ED. It is not as though these are second-best options either. They may well be much better places.

CHAIR - Indeed, and much safer places.

Dr DUGDALE - Yes.

CHAIR - Just back to the data. You talked about the value of having extra virtual health options and virtual emergency departments you recommended link to the main Tasmanian acute hospitals and additional telehealth support for secondary triage to provide care as close as home as possible. Telehealth is available. I do not know the number but Tasmanians are using that and GPs are employing that as an option. What are the gaps to providing more telehealth virtual health options? What do you see the gaps are and what could we be doing in Tasmania to plug those gaps and encourage more use of that technology?

Dr DUGDALE - I think the COVID-19 emergency unleashed technology if you like. We had the technology. We often didn't have the bandwidth. But there was a big expansion of bandwidth in COVID-19 and then we all, as clinicians, started using telehealth.

Personally, I found a straight telephone call was often better than video with patchy transmission and the patient fussing around, whereas they're very comfortable with a telephone call and I had all of their records and their results and things with me. So, we all got used to that. But it was brought on very quickly and I don't think there's been the level of organisational backup for virtual services that we will probably see in the next few years. For example, in Saudi Arabia, they have a whole virtual hospital with all the specialties running telehealth clinics, emergency calls. We have Healthdirect in Australia. It's not really an emergency call. Call triple-0, don't call Healthdirect if it's an emergency. But they operate in that way as a walk-in or dial-in.

I think we will see more differentiation so that instead of some of your patients coming in person and some of them you can call for a telehealth, there will be dedicated telehealth clinics that are set up for that, which have everything ready to rock and roll for that. The patients know what it is. The patients are getting the support five or 10 minutes before the call so that they can connect properly or have somebody with them if they are elderly, or if they have any cognitive problems, or if they're just not familiar with the material. I think the one-on-one technology is there but the organisation at the clinic and then at the greater-than-clinic level is going to come along. If we can invest in it and bring it along in a systematic way, we'll get the value of virtual approaches more rapidly.

CHAIR - What is the role for the Tasmanian Government in that space? Most of that sounds to me like it's a sort of Commonwealth jurisdiction?

Dr DUGDALE - There is a Commonwealth role but that would probably be mainly in general practices and community-based specialist practices. When they're in a hospital, ambulatory care or outpatient department, I am sure they are doing a lot of their work as virtual consults now. But it may be a matter of reorganising the rooms so that you have consulting rooms that are set up for telehealth which, for me, is not, 'Oh, we've got a video monitor', like this room; it's however the patient wants to do it.

There's no wrong way of doing a telehealth consult if you're the patient. You want to phone up; you want to be on video; you want to be on Skype, you want to be on whatever medium you like, rather than the one we dictate from the room. That requires a bit of technology. WhatsApp: I remember as the executive director of medical services, the IT people came to me and said, 'Oh, the residents are using WhatsApp', and I said, 'Right, and you're going to tell me that I've got to tell them not to?'. And they said, 'We thought of that and

we thought we'll kill people because they're so dependent on it. We want you to actually work with the residents to make sure they use it appropriately.' So we've done that.

CHAIR - This was for the aged-care residents, was it?

Dr DUGDALE - No, this is for the teaching hospital in Canberra. I've had a PhD student just recently submitted looking at WhatsApp use in the hospitals.

CHAIR - Great.

Dr DUGDALE - This is what I mean by there's no wrong way for the patient to do telehealth. But you have to be set up and you have to have protocols. You have to have done some training of your staff to get the best use out of the available technology. I think we will see that emerging. If you can get onto the front foot, there's emerging literature on how to do virtual health in the best way. It will be for a general practice. It will be for a physician, a geriatrician in rooms practice but it will also be for hospital, both outpatient and inpatient, and Hospital in the Home, using all these virtual health technologies that are now available.

CHAIR - In the context of ambulance ramping numbers getting longer, and access block and discharge block, can you see a value for that technology and that use to be part of the solutions here, other than just a general different way of doing healthcare provision?

Ms HENDRY - Can I just make a comment regarding the flow of people? What really strikes us when we are considering the organisation of people, there is the clinical care, the patient and the clinician in a one-on-one, as Paul described, but, equally, there is managing the flow. The idea of, 'Go to emergency, you know you'll be in the right place', is still alive and well. It is alive and well because of the absence of other instruments to help people feel confident before they go to emergency or even avoid going to emergency, which, of course, takes staff in ED. They might not be requiring a bed but you have a waiting room full of people and they need to be dealt with.

When you look at other industries, not to trivialise but by way of other examples, travelling to Japan, I know very well in advance that they are expecting me. I have registered before I have arrived at the hotel because the Japanese are very good at all of this. I arrived and they said there is nothing more to be done. It is so seamless. Even booking a restaurant. They say, 'The restaurant is booked but if we have an opening we will let you know'. Suddenly, I get an SMS asking if I would like a booking in the next hour.

If you apply some of those technologies to managing people, particularly, obviously, of low acuity, from the first time they think they need service, if you are managing that and advising them, I think we will see a whole different confidence build that people feel understood, they feel recognised and seen, and they won't be forgotten. Whereas, at the moment, I think, we are still relying on, unless you are physically present in emergency, they won't know about you, they will forget about you and if, by chance, you get worse, then you are back at the end of the queue. There is a lot of opportunity there to organise the flow of people in a timely way.

CHAIR - Yes, that is very useful. Thank you, Robyn. Did you have anything to add to that, Paul?

Dr DUGDALE - On your specific question, 'What about for ambulance ramping?', I think the ambulance paramedics, when they see a patient in their home, can make more use of telehealth things. They have a clinical call centre support, which is basically around high-acuity things with clear protocols, so, 'I think we've got a patient with a stroke; we've got to get them straight through to CT or MRI and we are lining them up for interventional radiology'. So, they call their centre, everything gets lined up. The same with a myocardial infarction, where somebody is going to have a go at ringing it out. Those clinical support lines are not dealing with the multi-organ-problem frail elderly person who has just gone off that day and hasn't been able to eat, and is now dehydrated and unable to stand up, because there is no protocol for it. There is no -

CHAIR - No pathway.

Dr DUGDALE - Yes, we have the golden hour. Whereas, they will, in general, do much better with in-place rehydration, which can often be done with cups of water, daily nurse visits, possibly admission into Hospital in the Home or possibly a community nursing service that says, 'We will come and hand off from you, you can go and we will take it from there, we know the lady well'. This is partly that the assessment may well be beyond the paramedic but if they can get, for example, the kinds of support that Healthdirect has in their call centre protocols and the services that they can get, they can get somebody who can say, 'Can you do a blood pressure for me? Can you do a postural drop? I think we've found our problem and we will now organise some care at the home. No need to bring them to the ED where they might catch COVID-19'.

CHAIR - Or stay on a ramp for 10 to 18 hours and have no attention and no one there trying to rehydrate them and notice.

Dr DUGDALE - Yes, because they're too sick to transfer into the waiting room but they're not sick enough to get a resus bed, because they've just got some postural drop. A GP would never send them to hospital. A GP on a home visit back in the day would have sorted things out. That is where we're aiming to use the virtual health technology to bring that around the patient.

CHAIR - Either through, in the case of an aged-care facility, speaking with a nurse at the aged-care home and providing direction to them about a number of steps to be taken with the person, or having someone coming in from the outside providing that hospital in the home care, community paramedic or whatever version of support in the community is available in a particular area.

Dr DUGDALE - Yes. An example might be a nursing home patient who has had an unwitnessed fall. Was there a head strike? We don't know. How are they? Well, they fell over. They're not that great. They're with it, then they call the ambulance. Does the ambulance need to take them to emergency or do they need to do a mini-mental to assess whether there has been any impact on their brain? That might not be that simple, because they're already getting mental scores that are reduced by their dementia and their other conditions.

If they can get some support, do the assessment and say, no, we don't believe there has been a head strike, there is no injury, there's no blood, there's no lump, it wasn't witnessed and their cognitive state is the same as it was previously. It's not a simple assessment. If it is

simple, the paramedic should be able to do it and leave them there, but they should also be able to get some support to do that.

CHAIR - Okay. Thanks. That's a really important point.

Ms DOW - The suggestions you make on workforce improvements and suggestion 6, which looks at encouraging retired clinicians to come back and work in a more flexible environment in virtual health, can you provide some examples of where that is happening across other states or programs you've been involved in, to give the committee a good understanding of what is working elsewhere?

Dr DUGDALE - I actually give one from our own company. Aspen Medical has a contract with Healthdirect for the provision of call centre clinicians. Other people also have contracts. There are a number of people and companies involved - nurses who have given up shift work on the wards for whatever reason. A lot of people do it for years and then they say, 'I have had enough of that', but they're really good and very experienced. We bring them into the Healthdirect team, train them. There are a lot of protocols and algorithms Healthdirect have. They're not Aspen's, they're Healthdirect's, but we do the training for our own team in how to use them. They're very fast, so these retired nurses are very fast on the uptake. They're very used to algorithms of care and very caring, so they have been a great workforce for us. I think we advertise saying you can call your own hours. They're still working nights, but there is not that much action overnight on Healthdirect. The staffing, we work with them, 'When do you want to be on', and they feel they're making a great contribution as the skilled and experienced nurse they are even though they have young kids and they don't want to do night work on the wards.

Ms DOW - Thank you.

Ms HENDRY - If I may add to that, you can expand that to many cohorts. In Sydney and Aspen Medical's experience, we've attracted large cohorts of staff where, purportedly, those staff have been in very short supply. One of the ways we've done that is to unearth or remove barriers and unearth people who are underemployed. That might be people with a disability, it might be people who have aged parents who they're caring for, and proximity really matters as they need that flexibility. Paul just touched on people with young children, et cetera.

There are a lot of experienced cohorts, for one reason or another, that need certain flexible working arrangements. We have found that telehealth, or any sort of virtual health, has unlocked a lot of opportunity in that regard.

CHAIR - I've got a question about your fifth suggestion, which is to develop and implement frequent user pathways and patient management plans for key frequent users and key frequent disease profiles, such as mental health. Are you talking specifically about the emergency department ambulance use of these frequent user pathways?

One of the high vulnerability groups of people who attend the emergency department and are at greater risk are people with mental health issues. They are poorly serviced at the moment because beds are often not available for them and the evidence is that people are often, at times, turned away when they definitely need services. How would this work? Could you describe this system and how it works to improve the situation?

Dr DUGDALE - Suggestion 5 is in implementation all over Australia. We're not saying that it doesn't happen. There are programs, pathways in all jurisdictions. Our nuance is that the pathway protocols are usually disease-based and there's a place for people-based pathways. What are your circumstances and how we can address that? The frail aged, you ask, 'What disease have they got?' 'Well, they've got all of them'. So, your disease-based pathways aren't going to help, whereas a whole-of-patient approach to the frail aged living on their own, is one thing.

People with mental health problems are often like that. Someone who comes in and they're in an acute manic state where they are psychotic, with known manic depression, they're going to get protocol care. However, people who live chaotic lives with a number of personality traits that make them very difficult for other people to get on with, with a lower-level, non-hospital type mental health diagnosis, maybe some medication, which causes a whole range of problems of its own, there isn't going to be a disease-based pathway for them. Looking at their particular circumstances, knowing them is going to help.

The frequent presenters should - and mostly do these days - have a plan for re-presentation. Anybody who has had three presentations in the last 12 months should be on a care coordination or frequent-user protocol where the emergency staff can look up the plan if they come to emergency, which will include an assessment and will show who are the services and what they are doing.

Again, I'm assuming that this is already in place in Tasmania, but I think in all jurisdictions, with the big increase in mental health patients attending, we need to get better at it and have protocols for more patients for re-presentation. There also needs to be more options, more community options for them. Most of them do not want to come to a hospital but they see it as the only thing available because the acute mental health community support teams are overwhelmed or just not available on that day -

CHAIR - Or that night at two o'clock in the morning on a Friday or Saturday night.

Dr DUGDALE - I do want to say something else. The flipside of it is this increase in presentation of these people who always have been in the community. They are going to hospital in more numbers now and it is partly because they are getting looked after there whereas previously hospitals would say, 'Do not come here'. It is not all bad and I think the hospitals have recognised, and we need to continue to recognise, their important role as places for people with mental health problems to go when they have nowhere else to . But they need to be able to deal with that quickly if that is a recognised role rather than, 'Oh, that is not what we are here for'.

To some extent, they have embraced it, perhaps not willingly, but with some care and compassion. Let's give them the recognition for that and say let's deal with it quickly because it is no good for anybody for patients to spend long periods of time in ED except in certain circumstances that are actually quite straightforward and easy to diagnose if its psychosis or -

CHAIR - But then they do not need to be in ED. They need to be somewhere else, don't they?

Dr DUGDALE - They would probably need admission or things, I think they get dealt with fairly quickly.

CHAIR - Unfortunately, that is not always the case in Tasmania. We have had some very extreme situations where people are not dealt with for a very long time or abscond because they cannot -

Dr DUGDALE - I think another one that can be difficult is where the patient with mental health problems starts getting problems where they are becoming a bit delirious with toxicity from an infection or medication problems and sorting out some delirium in a patient with no mental health problems needs careful integration of the team in the ED.

CHAIR - Do you have any other questions, Anita? We are at the end of our time unfortunately. Would you like to make any other statements to the committee?

Dr DUGDALE - I would just like to pick up one thing that Robyn said in her opening remarks. That is the independent review of ED has offered a set of interim recommendations that are very focused on the hospital and the department. We are suggesting that perhaps the committee - this is in our submission so it is all there - could take a wider view that there is a role for the hospital, a role for the department, roles for the wider health system in Tasmania and roles for the Commonwealth.

Looking at your terms of reference and knowing the people in it because we have stalked you all, I think you are no doubt going to be making those wider types of recommendations. A role for the private sector is really important to think about, not to do the things the public sector does really well but we do innovate well.

Give us a problem that has not got a solution and ask, 'What do you reckon?' And you will have several companies say, 'Well, here is what we reckon'. You can do an assessment and say, 'Let's give that a go'. Building in private sector capacity and capability, I mean core centre and virtual health options, if you try to run them just in the public sector, you will fail. We are very good at it in the private sector.

CHAIR - Why would they fail if they were run in the public sector?

Dr DUGDALE - Because you are probably going to find it harder to recruit people on the mainland than we do, and we have a national workforce already, if you do it as a Tasmanian public sector one running a national operation. Because we are already offering these services in several states, we have scale, we have location, and we have capability that we can have in them.

CHAIR - It would be a call centre with people, not Tasmanians, but people on the mainland. Probably, some of them might be; some of them might not.

Dr DUGDALE - Registered Australian health practitioners. Just as we have Tasmanians in our service answering calls for people on the mainland. The solution to these complex problems has to be public sector driven, given the nature of our health system. The steerage needs to come from the government, from the public sector, from the parliament. The involvement of the private sector, not just in small, circumscribed, traditional roles but in the innovation needed for addressing these complex problems is worth thinking about.

CHAIR - Thanks, Dr Dugdale. Robyn, did you have anything to add?

Ms HENDRY - I would concur with that. In the 20 years of Aspen Medical's experience - and I am sure others would have done the same - is that looking for a bit of ingenuity to pilot new processes, programs and solutions has led to solutions not envisioned previously. I would concur with Paul. I am not suggesting the private sector knows the cavalry coming in, at all. But, it is a case of being able to run discreet pilots you can then test, evaluate and potentially scale. We would think that system spiderweb approach is going to be a much more integrated and equally balanced solution than just emphasis just on the ambulance, ED and hospital at large.

CHAIR - Thank you, Robyn. A reminder for you, Paul, because you are in Tasmania. As I said at the start of the committee, the evidence you have given here today is covered by parliamentary privilege. If you say things which could be defamatory or leave you able to be sued outside then you will not be covered by the privilege, even if you said the same words in the committee here today. You understand that?

Dr DUGDALE - I do.

CHAIR - Great. Thank you very much for coming. Thank you, Robyn, for joining us from Japan. Very much appreciated.

Ms HENDRY - Thank you, Chair and committee. Thank you for the invitation. We have been pleased to be a participant in this. We wish the committee all the very best in your deliberations. We know it is a difficult problem and know other parts of Australia will be looking at the solutions you provide.

CHAIR - All right, no pressure, great.

THE WITNESSES WITHDREW.

The Committee suspended at 12.53 p.m.

The Committee resumed at 2.00 p.m.

CHAIR - Before we start, did you get the guide about this committee as a committee of parliament and everything you say is covered here today by parliamentary privilege?

Mr WALLACE - Yes.

CHAIR - That's so that we can do our job of getting the best information to write our report and make recommendations. You are covered here and you don't have to be concerned about being sued or any court action from what you say here today. If you leave the room, then you're not covered by parliamentary privilege, even if you say some of the same things that you've said here today. Do you understand that?

Mr WALLACE - I understand.

Mr HAMISH WALLACE, INTENSIVE CARE PARAMEDIC, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

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

Mr WALLACE - Yes, sure. Just a brief introduction, perhaps. My name is Hamish Wallace, paramedic for 24 years in the northern region. I currently undertake the role of operations supervisor but I'm front-line working days and nights. I put my submission in here because I feel I needed to represent the staff as well because I spend time with them at the hospital and see the effects some of the offload delays are having. My experience is widespread as a paramedic, clinical support, air ambulance and I still do specialist rescue wilderness operations. I've just come down, basically, if you've got any questions, I can help with day-to-day operations.

CHAIR - Thanks. When you say the hospital, you mean the Launceston General Hospital?

Mr WALLACE - Yes. I'm based in the northern region, so that's where I spend a lot of my time.

CHAIR - You've given us some pretty strong stories about how it's impacted on you and other people. You've been working for 24 years. Do you want to describe how things have changed over that period for you?

Mr WALLACE - Things have definitely changed, it's obvious. It's got busier, the pressures at the hospital have got busier. We do have more staff, we have more turnover -

CHAIR - More patients.

Mr WALLACE - Yes, more patients. Patients are sicker. They are chronically ill. We go to them regularly, have to take them to the hospital regularly. Personally, it probably has built up. I've put in my submission that I've had to take a bit of time off. As a first responder, you need to have room in your bucket and capacity to deal with the really tough and difficult circumstances, and I'm very happy dealing with those. But when it's so full, you don't have the capacity or room to cope.

CHAIR - Do you want to tell us what you find toughest about the circumstances you have to deal with at the moment?

Mr WALLACE - Particularly with the offload or just general?

CHAIR - Something we've heard from other people is that you're trained, as an emergency responder, to work in unpredictable, high-intensity situations. The difference between being on the ramp and sitting still is something other people have commented on. Do you have anything you want to say about your day-to-day work?

Mr WALLACE - I find a responsibility for myself is to keep up morale and I have to encourage others who are at the hospital with patients that things will get better. I'll try to get them breaks. I'll talk to the hospital and negotiate with staff and try to turn them over because, at the beginning of their four-day shift, they might be sent straight to the hospital to take over from nightshift crews. At the end of their four days, they will probably still be at the hospital not four days straight, but dayshift crews having to come and take over. I'm finding personally that I'm supporting staff. I'm trying to get them to see the light at the end of the tunnel.

I think this committee is important and it shows we are working towards it. I believe the ambulance service is doing some really great steps to help with the offload delay policy, which they're looking at at the moment. In the north, we've been very lucky where we've had a policy where we've been able to offload patients to respond to priority ones and priority zero cases, so that has worked well.

But, primarily, I'm just trying to support my staff day to day because you see they're trained to respond to sick and injured patients in the community but they're feeling a little bit deterred or overwhelmed being at the hospital all the time.

CHAIR - One of the things you mentioned in your submission is that you have to deal with everything from the calm and the boring to the extreme and tragic. You talked about going to attend a child who died and that you've seen people die on the ramp.

Mr WALLACE - Yes.

CHAIR - Can you talk a bit about the circumstances for people who have died on the ramp where you've been there? What were the circumstances around that?

Mr WALLACE - One specifically that I wrote about was an elderly patient who was dying and we had to bring them to hospital. Sometimes, people may be palliative but they don't have the palliative support places in the scheme at home or at a nursing home, or the family becomes concerned, and we take them to the hospital and they see the staff there and they make a plan. But this lady was ramped in the airlock and she was dying, and her treatment was finished or completed. We needed to get her home but we didn't have anyone to do that. The nurse in charge there, the staff, are looking to me. It's in the early hours of the morning. I said, 'Just take them home'. The patient didn't deserve to die in the airlock. We are not supposed to do that but that's what we did on that night and the patient died comfortably.

CHAIR - At home with somebody who stayed with her.

Mr WALLACE - That's right. Not at the hospital.

CHAIR - But the team who took her home stayed?

Mr WALLACE - The team who took her into the hospital then took her back. So, that's one.

There was another one, a case where I had to first-respond, which is fine, but my primary crews were at the hospital. So there is a delay there and the circumstances wouldn't change. But in the early hours of the morning when you have a paediatric child in a room and you don't know what's happening and you need to resuscitate them, and you need new staff there who are available as soon as possible - they are just a couple of things I've talked about. I understand that's our job. I don't mind that, but we need the capacity to deal with it.

CHAIR - When you're in the ramp, just talk about the fact that you don't have the capacity to deal with it. Why is it different?

Mr WALLACE - The difference is that we are lucky that we can offload patients at the LGH if we have a priority code zero. But when you have to do that, you have to find the nurse in charge, you have to do a clinical handover. It takes time. You might have a couple of patients to hand over because we may have had to consolidate for someone to have a break or something like that. Sometimes we will consolidate, so it delays the process. I find that sometimes when we've had to hand over the patients, things have been missed. We've tried to improve that with detailed handover forms and signing the sheet. But there's a bit of collateral damage. When it's busy and you have to race out the door, things will be missed sometimes. So, that's concerning. Crews find it harder to respond when they have to hand over and race out the door. That's challenging.

Sometimes, part of my job is to prioritise which crew I'll send out. I have to work with the hospital and with the paramedics there and I will make a list of who I will send out next. Or the communication centre will ask, 'Who can we send next?'. Or someone's had a meal break, hasn't had anything to eat, so I can't send them. I have to send another crew. There is juggling all the time there to try to respond as we want to.

CHAIR - You've mentioned lots of things that Ambulance Tasmania has tried to keep patients out of hospital: secondary triage, community paramedics, extended-care paramedics, PACER programs, and the introduction of pre-hospital thrombolysis. They're all interventions which have been used successfully to keep people out of hospital. Can you describe why they haven't been successful enough in Tasmania? Each of them - maybe if you just want to talk about community paramedics, for example.

Mr WALLACE - I think some of those simple, minor issues - and you hear a lot about these minor issues presenting to emergency departments and taking up time. They can be dealt with and out the door quickly sometimes. Sometimes our community paramedics can do that as well - extended care paramedics (ECPs). So that works well, and I think there are such unwell, chronically ill patients who take up lots of time and lots of resources and who need beds.

Then there is the access block to get up to the ward. They might be in the Emergency Department for 20, or up to 40 hours, I've seen. It's probably more the chronically ill. They've

got comorbidities. That's what really blocks things up. I think it's been successful with the community paramedics and ECPs looking after some of the minor things. Not being one, I think there are more relationships with other health providers, maybe with palliative care and there's the Community Rapid Response team nursing in Launceston. They're more in touch with GPs. I think that's good. It's hard. I still think the really sick people is where the problem is occurring. Does that answer it?

CHAIR - Yes, sure. People who are coming by - if people ring triple-0 and an ambulance turns up, then what happens if you get somewhere where you think a person might actually be better off if they don't get into an ambulance and go to emergency and they have some care at home. Is there an option at the moment for you to be able to provide that care or to work with another - ?

Mr WALLACE - We can provide some care. Through our communication centre and secondary triage clinicians, we can speak to them. Say that Hamish has turned up to this job, someone's got a minor ailment. I ring them up and say, 'Does this fit your guidelines for our extended care or community paramedics?'. Sometimes we might still have to go and assess them and then refer them. Other times they are referred directly from secondary triage or call-backs.

CHAIR - What is secondary triage? Can you explain that?

Mr WALLACE - Secondary triage is the clinicians within the communication centre who can triage the -

CHAIR - Clinical paramedics?

Mr WALLACE - Yes, or nurses.

CHAIR - Who are on call for paramedics to have a conversation about an individual patient.

Mr WALLACE - Or they can actually triage the patients over the phone. It should cut out the response of the emergency EMS vehicle. So rather than send the truck, the paramedics, they could send the community paramedic or the extended care paramedic first up.

CHAIR - In which case then, in your view, are the people who are getting in an ambulance to go to hospital, are they the people who need a hospital?

Mr WALLACE - I think they are. A lot of them who are really quite sick. If they're not we will leave them at home or we can offer people advice to take themselves to hospital. We can't refer them directly to after-hours urgent care. We can take people there, but we can also suggest to go there. One thing as a paramedic, your assessments need to be really thorough and we work from the worst and work our way back. Somebody's had a simple fall, and the elderly might have had a head knock, and they might have a haemorrhage on their brain, so they need to go to hospital. They need to have a CT scan, so we still need to do that as well. We want to take those patients there because they might have a slow bleed or something like that. You don't want them to get sicker later on. If we can take them there, get them seen, get their CT scan, and gone, but sometimes it takes quite a while or they may deteriorate.

CHAIR - Can you explain the difference between community paramedics and extended care paramedics?

Mr WALLACE - Extended care will have a higher level of clinical guidelines -

CHAIR - Scope of practice.

Mr WALLACE - Scope of practice, yes. Community paramedics is a newer program, I'm not experienced in their guidelines and what they do. I have not undertaken that. Extended care paramedics are well known throughout the nation and other ambulance services as well. Certainly, the experts within the ambulance service with extended care paramedics would be worth talking to.

CHAIR - Does Ambulance Tasmania train both community paramedics and extended care paramedics?

Mr WALLACE - They have just done an expression of interest to do more training for community paramedics. I spoke to a paramedic yesterday. He said he has expressed interest. He is based on the east coast and I was there and had a chat with him. Yes, that is happening as well.

CHAIR - Then the normal process used to be that somebody would come into Ambulance Tasmania, qualify as a paramedic and then normally would go through a process of training to become an intensive care paramedic?

Mr WALLACE - Correct, yes.

CHAIR - That is not happening as much as it used to be. Is that correct?

Mr WALLACE - There is an intensive care course right at the moment. There are four staff members in the north who are on call. Three or four, so, that is happening; that is good. Into the future, they are going to look at the specific requirements, where you might have to have a graduate certificate past your bachelor's degree or a master's in intensive care to have entry into the course. I believe it will still always have to be an in-house training course but there will be external components as well. For example, mine was all within the ambulance service some time ago but I have graduate certificate in other areas as well.

CHAIR - The PACER program is operating in the south. Is that operating in the north and the north-west?

Mr WALLACE - I believe a slightly different version in the north-west. I believe it is the MHERT, Mental - I do not believe they have a police officer -

Ms DOW - Emergency Response Team, is it not?

Mr WALLACE - Yes, but it is not in the north, at the moment.

CHAIR - No, it is not.

Mr WALLACE - No.

CHAIR - What is the hold-up with that? Do you know?

Mr WALLACE - I don't know but I believe it would be great. As part of my job as a supervisor, I have quite young staff on my shift. The patients with behavioural disturbances or mental illness are very challenging. I like to go and support them because it is not easy. It is hard to get the right care. If somebody's upset or threatening, it can be intimidating. I like to support my staff and I want to get out and do that but I think the PACER program would be certainly helpful within the northern region. I believe it will come.

CHAIR - Is that a resourcing issue?

Mr WALLACE - I think there are a lot of resourcing issues. I know the ambulance service has tried to put in a submission for more paramedics and more support staff, more operational supervisors. If that comes, that will be great. We might be able to then look at that area but we are struggling. We have a lot of people going part time because they are mentally drained and tired from the ramp.

CHAIR - Would you say that you are working part time now? Or less hours?

Mr WALLACE - I am actually on a return-to-work program. I had to take some time off, so I am back doing two days per week. I was burnt out and tired. I wanted to get back to work early but people told me to have a break. I think the bottom fell out of my bucket, rather than it being full. You need that bit of space in there so that I can cope with these difficult circumstances. I wanted to do my best and I just could not for a little while.

CHAIR - Were you paid on leave while that happened?

Mr WALLACE - Yes. It was a WorkCover. I was told, basically, I needed to take it. My doctor told me and I am not ashamed of it or anything like that. I quite enjoy my job and I want to be out doing it. Over the years, I have had a few health things myself. I have had some challenges and overcome those, which is good. I have had testicular cancer; I had a tumour in my knee. I had to have surgery in Melbourne for that. I had a few other little hiccups along the way but I have picked myself and kept going.

CHAIR - Other paramedics have spoken about leaving Ambulance Tasmania because of burnout after having worked there for a very long time. Do you find that people are able to take the mental health support that they need so that they can continue to work in the job? How common would it be that people can come back to work?

Mr WALLACE - It is pretty common, but I think people are getting early their self-preservation by reducing their hours of work and part time. They might do two days, one night. Some people do four days on, do one block, have 12 off and another four. I think there is a lot of self-preservation to keep them going. I worked with a lot of old-school paramedics and some of those are leaving. I am now becoming a bit of a dinosaur, but I am still quite active and operational.

CHAIR - A young-looking dinosaur. Is that affecting people's choices about working on Friday and Saturday nights?

Mr WALLACE - I think the worst nights are probably Sunday and Monday nights. If people have a really bad night, it is sometimes hard to back up for the second one. Once you have done four days and you have been out all night, you are fatigued. It is perhaps like a bad hangover. It is hard to keep going. You have family responsibilities and work a lot of weekends. But the biggest thing, I do not think people are walking out the door just yet. I think people are self-preservation, they are looking at career opportunities.

Our workforce is younger. It will probably turn over more. The staff have been there for three years and they are already dropping a night.

CHAIR - Would one of those career opportunities be looking at more opportunities for community paramedics?

Mr WALLACE - I think so. The community paramedic is not like a substantive role as yet in the north. It is only extended care. They are just working within - a substantive position would be a paramedic on the road. It is not their position number or anything like that. I think that would help-

CHAIR - And extended care paramedics, where are they working? Not on the road?

Mr WALLACE - They are working 11-and-a-half-hour days; afternoons there are three within Launceston. Probably ones just working full-time hours, another one is looking at retirement soon actually.

CHAIR - Not on the road? Where are they working?

Mr WALLACE - No, they work within a car or a van. They are single responders.

CHAIR - To keep people at home?

Mr WALLACE - Yes.

CHAIR - How do people contact them? How do they get their job? Through the triple-0?

Mr WALLACE - Correct, yes. Then the call might come through, second triage might pick it up, they might then pass it to the extended care paramedics, who also look at some of the jobs which come through and see if there is anything available they can go to. Something that makes that easier. I do not work at the -

CHAIR - Easier in what way?

Mr WALLACE - Maybe perhaps for them to pick up those lower acuity jobs. There are certainly lower acuity jobs I see which come in. The EMS crews are sent to that. It might be more specific for an extended carer or community paramedic to go to, but there is strict sort of guidelines and questions are asked. I can make suggestions sometimes, but it is not always my call. I have lots of things also happening, because I have a look and see what is going on in the region and keep an eye on things.

Ms O'BYRNE - Thank you, Rosalie. I just had a couple, Hamish. Thank you so much for coming down and doing this.

Mr WALLACE - That is all right, no worries.

Ms O'BYRNE - I wanted to touch on a couple of things you mentioned in the report. In one of them, you talked about a little, which I will come back to, which is that emotional toll that it is taking on paramedics.

The inter-hospital transfer policy from the north-west coast; you talked about in your submission that not transferring non-acute patients at nighttime was a policy that was not adhered to. What is the impact of that? Also, anything east of Latrobe is still being transferred to Launceston. Do you have any thoughts on how that impacts on the ability, when you already know there is ramping at the hospital every day you turn up?

Mr WALLACE - There is a specific one when the policy was first introduced by former CE. As soon as the policy was introduced, a patient was transferred and I gave them feedback and they were to follow up. An example would be, 10 or 11 o'clock at night, Sunday, Monday, the hospital is full with no beds coming up, the patient's quite stable and they are transferred through and they're going to be ramped and stuck there.

Ms O'BYRNE - You know, even before they're transferred.

Mr WALLACE - There are a lot of cardiac patients who have to come through for cardiology. I know they need to be there, but sometimes nothing will happen overnight unless they're critically unwell. That's an example. The guidelines for the Mersey, I am not 100 per cent sure on, but a lot of transfers will come from east of Latrobe, which is fine if they need to and that is the policy. However, if you've got someone who's likely going to need the LGH there's probably no point in taking them to the North West Regional and then having to come back to the hospital at 3 o'clock in the morning when they've deteriorated or have to go to Hobart.

Ms O'BYRNE - I am interested in your view on this. We had some people tell us, for instance, if somebody falls off a piece of playground equipment in Latrobe and might need an x-ray, that they're going to be taken to the LGH, rather than somewhere to rule out whether there is a break. Would that happen very often or is that something you experience much? Clearly, we want to make sure this critical patient gets assistance. It's more, 'we're sending you here and it's more exploratory because we can't send you anywhere else'.

Mr WALLACE - Some of those may be more complicated paediatric fractures; they might get brought straight to the Mersey. If somebody has a significant mechanism, like a distracting injury - not falling in a playground - you would want to bring them to the LGH, but if you had someone fall down in a playground in Port Sorell, they would probably bring them to the LGH with a fracture, but there are specific guidelines.

Ms O'BYRNE - The x-ray would take place at the LGH to see if it was a fracture. There is no screening, I guess, isn't the question. If it is a sprain and you travelled all the way to the LGH in an ambulance and be ramped for a while because your triage is quite lowly, it seems a waste of time. I just wanted your view on that.

Mr WALLACE - If it's a simple, non-displaced injury, you'd take it to the Mersey and they could x-ray it there and then take it, but if you thought a limb had some altered sensation or profusion or some complications, you would want to take them to LGH to see a specific orthopaedics team. Orthopaedics are available in the North West Regional too, but I would have to check the specific guidelines of what to take to the Mersey and what not to take also.

Ms O'BYRNE - Chair, that might be something we could ask the department for.

Mr WALLACE - Any cardiac patient who was at Devonport or something, you would bring to the LGH, or if they had a STEMI (ST-Elevation Myocardial Infarction) or a heart attack, they'll consult for pre-hospital thrombolysis. They would try to dissolve the clot because they can't get to the cath lab in the prescribed time, so that's an absolute no-brainer. That's what we do and it's fine. It does happen on a regular basis that patients are brought of a night-time and they are ramped, and we know that's going to occur.

Ms O'BYRNE - In your submission, you also talked about needing 'internal escalations' earlier. How often are you seeing that that's not happening in a timely way so that things can be dealt with?

Mr WALLACE - We have quite a good escalation plan within the ambulance service itself. I think it's looking at being reviewed. The escalation plan we use at the hospital has a few levels and I work closely with the in-charge nurse at the hospital. If we have two or more trucks ramped for 30 minutes, that's an escalation level two. If we have another 30 minutes, it is level three. I then might contact the nurse in charge of the integrated operations centre at the LGH and find out what's happening and go to my manager and report to them also.

When we do that, not a lot always changes. We know specifically we could probably tell you how many ambulances are going to arrive at the LGH every day, or roughly. But I'm just wondering if that escalation within the hospital, is that happening early - like, they know there are going to be 30 ambulances coming. The escalation only really feels the sense of urgency when the place is full. I might come in there on a Sunday -

Ms O'BYRNE - Particularly on the weekend?

Mr WALLACE - Yes. I'll contact this person and I'll say, 'Well, there are beds coming up or there are no beds'. One issue we see on a Sunday or Monday, I might go and see the in-charge at the beginning of a night shift and they say, 'There were absolutely no beds, we were ramping all night'. And I say, 'Well, what's the plan? We are going to be coming here all night'. It's a hospital. There's no plan. We just have to offload to the staff and I feel sorry for the staff. If there's a major incident -

CHAIR - They're not getting pushed further up to the wards. The wards aren't taking them.

Mr WALLACE - No, the wards are full. That's at 10 o'clock at night. Nothing is going to happen probably until the next morning. We're just consolidating patients. I'm gobsmacked when there's no plan. I know there are escalation policies within the hospital. I've briefly read it; I had a look online. But I'm just wondering does escalation need to happen earlier? I don't know what the plan is. What do you need to do then?

Does that help? Did that answer, Michelle?

Ms O'BYRNE - It does because hospitals have them but I guess the worry is, (a) do they use them appropriately, and (b) what happens when they are implemented? Does anything change if the hospital is already full?

Mr WALLACE - I know they will call in extra staff. They use the terminology of 'offload nurse'. If we do have to go in Launceston, they might have an extra staff member who we can offload to if we get a job. But we don't do that straight away; we have to stay with the patient until we get another job. I don't quite understand that.

Ms O'BYRNE - I sat in ED with my mother once and watched a paramedic try to negotiate beds. Have you played that role?

Mr WALLACE - Yes. That is my role.

Ms O'BYRNE - How hard is that? It seemed to be really challenging to try to get people back on the road to pick up people and come back to an already overcrowded environment.

Mr WALLACE - It's hard and the staff are stressed there. Some are more flexible than others to deal with. But that's my job and it is hard to work out who are we going to offload. I'll help them as much as I can and I'll go out to the airlock, I'll go around to the back of Bed 33. You've all visited the hospital, haven't you? I'll have to work out where everyone is and it's challenging. I get along with the staff. I have good rapport with them but at the beginning of the night -

CHAIR - It's not about the individuals. It's about the system that they're working in.

Mr WALLACE - Yes. And what do I do? Of a night, if my staff - I'm on C Squad, we've got a good group together there. They just have to rotate through after midnight if we're stuck there. The guys are really good. They will give themselves a break. We don't consolidate routinely - only for meal breaks and going home. But when they're fatigued and tired they will need to get out of that place.

Ms O'BYRNE - And that led to my last point which was, simply, you've obviously felt the pressure of this. You're slowly returning to work. How detrimental has it been to staff working in that environment to have that level of pressure all the time? And how sustainable do you think it is in its current form?

Mr WALLACE - I think a lot of people have probably already told you it's not sustainable. But I think ramping or offload delays won't go away. It's going to be there. I think there are probably improvements they're going to do and it's great to see people are there to try to help. But it is detrimental. That beginning of a shift when, 'Oh, we're off to the ramp' to take over as soon as you get in because we want to get staff home. Some of the younger staff will think, 'Maybe this job isn't for me'. When I started, we were an emergency service. Now I feel we are a healthcare service which does emergency work.

CHAIR - We've heard from another paramedic who said that staff are often forced to work overtime at the end of shifts. Is that something you've experienced or observed?

Mr WALLACE - Yes, quite often. If they get a late job or they're stuck at the ramp, they will be ringing me up to see if we can get someone to take over so they can get home. Extended shifts are quite common.

CHAIR - When the next person comes on, why don't they just come in straight away and take over from them?

Mr WALLACE - There might be other jobs in the community which have been waiting as well, so they might be tasked to those jobs straight up, so there's a backload in work as well. Some of these jobs have been waiting a long time, so if they have a crew free, they will task someone.

CHAIR - What's the answer to that? Should there be extra people rostered on to shifts?

Mr WALLACE - The answer might be the transfer-of-care policy. If it is greater than 30 or 60 minutes, we have to hand over to the hospital because we've still got our job to do out in the community. It is frustrating for staff who are ramped that when a day shift crew comes on, they have to go to another job - but you could have had an elderly person on the floor for hours and they're cold and they have a painful hip. If you had that patient in the Emergency Department on the floor, there would be an outrage, but these types of jobs are sitting there every day. They probably are now, waiting for a crew.

CHAIR - We also heard that P0 and P1 calls are going unresponded due to crews not being available. Have you experienced that? Do you know that?

Mr WALLACE - Yes, sometimes there are delays.

CHAIR - Do you want to explain to people who might be watching what P0 and P1 calls are?

Mr WALLACE - A P1 would be a chest pain, so lights and sirens off to a case. A P0 would simply be a cardiac arrest, not breathing and immediate responses are required, so there are significant delays from time to time in responding to those cases.

CHAIR - How does that make people feel when they are sitting on a ramp hearing P0 and P1 and not being responded to?

Mr WALLACE - If they hear P0, they want to get out the door and help. What is difficult then is that we can be released, but we have to hand over that patient and do a report and it's important because you don't want something to be missed, and things have been missed. We can't get out the door quick enough. There are delays. As an example, I have responded to cases whilst my crews are clearing.

CHAIR - We've also heard that from your testimony and your submission that you have seen people die on a ramp.

Mr WALLACE - Yes, that's one specifically I wrote.

CHAIR - And yet the department has claimed that there have been no deaths on the ramp in Tasmania. What do you make of that statement?

Mr WALLACE - I'll clear that up. That lady was dying. She would have died if we didn't get her back. I didn't want her to die there, so that was cleared up.

CHAIR - That was the person who you took back?

Mr WALLACE - That's clear, not guidelines specifically, but I know others who have seen people die. I spoke to a supervisor today who was working on the road, and he said he would feel too uncomfortable in coming to talk to you; it is upsetting talking about a patient who died on the ramp, and I believe their family may have made a submission as well to the committee here.

CHAIR - So, you don't accept the department's statement that there have been no deaths on the ramp in Tasmania?

Mr WALLACE - The staff have said that people have died. To clear mine up, this lady was dying, and to prevent her death there I got the crew to take the patient**.** Normally, we'd have to call Comms or Patient Transport and get them to take them, but I didn't want that to happen.

CHAIR - No. No-one would want that to happen.

Ms DOW - Hamish, you made reference around the inter-hospital transfer policy and the need for a dedicated triage nurse in your submission.

Mr WALLACE - Just to clarify, with the dedicated triage, to clear it up, I still find, and you have probably seen as well, that we get triaged at the same window where all the public is in the LGH and I thought, simply, 'Could we not triage there?' We've talked about it for long time.

CHAIR - I thought there was a triage window when we came in; you come in the doors from the ramp, and I thought it was on the left -

Mr WALLACE - No, you go through that door and then you are there with the public and the clerks and everything there. Occasionally, you might get triaged out there. They have got another computer, but not dedicated. So, we will sit there and sometimes I say, 'I have just got someone in the waiting room, can I do them first?' Yes, we line-up.

CHAIR - We were led to understand that there was a specialist ramping triage area.

Mr WALLACE - No, there is the airlock where we were going. There is the triage assist area - two beds which the emergency department staff might bring a patient in and do some observation and look after them and send them out, and then there is bed 33 around the back where we go.

CHAIR - Are there ever extended delays to triage?

Mr WALLACE - Yes, I have phone calls to say, 'Hamish, can you give them a call?'

CHAIR - Even if there has been, like people ring triple-0 because it is an emergency and if you rush in with bells and sirens, would there still be a delay? Has there ever been -

Mr WALLACE - I think if you had a critically ill patient there would not be a delay as often, but you could have someone with a patient with chest pain, stroke symptoms, septic or a bad infection, there could be a delay there definitely. If we are going to be ramped or delayed, it is okay, but we need to be triaged.

CHAIR - You need to know what you are working with.

Mr WALLACE - Yes.

Ms DOW - Have you raised that with high levels of management or with the LGH directly about the need for that additional service?

Mr WALLACE - I have raised it with my managers as well, I have talked with the staff down there. You have triage assist nurse and I think - could we just change the words around to ambulance triage nurse? - one dedicated there. I think there might be some work in the background, but I get on with the job as well, but it certainly has been discussed. I think the team in the north has worked well with the hospital and they're overworked and doing lots of multiple tasks; just as we are as well.

CHAIR - Before we finish, I will just ask a question and I will go to you, Michelle, next. Could you outline the risk to the patients on the ramp? What is actually happening? What you are seeing happening if they are not getting triaged on time, or even if they are triaged? Why is it that -

Mr WALLACE - I think somebody who has acute symptoms, maybe stroke-like symptoms, if they are triaged early, they can activate processes like the stroke team to try to treat them early.

CHAIR - Do they get treated early if they are on the ramp?

Mr WALLACE - No, not -

CHAIR - They don't come and attend them on the ramp and do that?

Mr WALLACE - Well, they will come and attend quite often, and sometimes there will be other interventions as well. If you have a category 2 patient, they will try to attend as soon as they can, but they might have other priorities as well. That is not the space where you want to be managing your patient on an ambulance stretcher. When there are other interventions which the ambulance service or paramedics do not provide, that can become a bit tricky where there are guidelines and medications and things outside our scope.

We want our patients to have that, but we need a proper space and a proper team.

Ms O'BYRNE - Sorry, I just wanted to ask one of the things the department has told us is very hard to ascertain - because you would have to go into every patient record - is how often people's condition deteriorates while they on the ramps? They have turned up and they might be a category 3 but they have got worse. How often do you see that? The department does not

track that information so it's hard to get an idea of what percentage of people who are ramped end up being admitted in a worse circumstance than when they arrived.

Mr WALLACE - The best place to probably find it would be some people will SRS that if the patients have deteriorated, so using the instant reporting program to log that maybe. It is not always clear. I have been involved in an RCA of a patient who deteriorated on the ramp -

CHAIR - What is an RCA?

Mr WALLACE - Root cause analysis. You know a patient who was thrombosed in the north-west, improved, then deteriorated on the ramp they were just sitting outside Resus 3. There would be some specific information there but a lot of it I would say SRS.

Mr WALLACE - Yes. Some of our staff will put it in their VACIS reports as well.

CHAIR - What are they?

Mr WALLACE - A VACIS will be the ambulance electronic patient report form.

Ms O'BYRNE - But if you were trying to find out, what question would you ask to access that information? How would you get it? It doesn't seem to be collated in one space, where you could easily -

Mr WALLACE - I suppose you would have to reference the notes made in triage, when they arrived.

Ms O'BYRNE - They would be each (inaudible) patient then?

Mr WALLACE - You would have to refer to the ambulance report form or the first set of OBs that maybe then RNs have taken or what we have taken on our ramping handover form. You would have to really compare and contrast the observations when they came in, to the ones in our report. That would be one way.

Ms O'BYRNE - There would be information that would be useful, but it doesn't seem to be collated?

Mr WALLACE - I think so. Maybe. I spoke a little bit about the digital transformation and things to happen. I do not know if that is going to make things easier to find out this information and stuff happening there.

Ms O'BYRNE - Thank you.

Mr WALLACE - That is alright.

CHAIR - Was there anything else you wanted to say to us as we wrap up?

Mr WALLACE - No. I think that has covered most things. Yes, I came to represent the staff.

CHAIR - We really appreciate your voice and representing the staff view. It is important to the inquiry to have this breadth of information and the specific details about how it is impacting on people.

Mr WALLACE - I feel like a few extra resources they are talking about to come will help. I know from trying to manage a region and staff and all those other tasks and my primary role is to supervise my staff in the field. That is what I want to do and support them, provide care. Thank you for trying to help.

CHAIR - I have one last question about the culture in Ambulance Tasmania. There was a coronial inquest, a broad culture of bullying, a culture of people not being listened to and supported with mental health and burnout. Do you think things have changed? Is there more change that needs to happen?

Mr WALLACE - I believe things are changing and improving. I believe that is a positive. I found myself, sometimes - whilst my supervisor's managers have been great - but they are busy and trying to access them and get time has been challenging. Maybe more specific Ambulance people. I probably talk to my peers more sometimes. I have read that coronial inquest, and I was quite interested in the recommendations it made specifically.

I made a point about that today. It says 'duty managers', but we are operational supervisors. The span of control for the duty managers. I am the operation supervisor in the night looking after the northern region, which includes Flinders' Island specifically. That is quite a lot of people to deal with. I have so many other things. It talks about the ability of managers to supervise staff and they are some of the recommendations which the coroner has made.

CHAIR - Have they been implemented?

Mr WALLACE - Not as yet. I believe the culture is improving. Some people will beg to differ. I am a positive sort of person.

CHAIR - Do ambulance staff get independent professional counselling and support?

Mr WALLACE - If they ask for it.

CHAIR - Does that perhaps make people disinclined to ask for it?

Mr WALLACE - Perhaps. Yes.

CHAIR - It is not a culture of providing a regular quarterly professional debriefing service for people?

Mr WALLACE - No. I think that was in the recommendations. I find there is not, no. You need to access it yourself. I feel what is, in a way, my position became days and nights when COVID-19 occurred. Having a supervisor who was there - before we used to just have the supervisors on day and night - provides more support to staff and that is a positive. However, being available for them is the challenge with all of the other aspects you have to do of the role.

CHAIR - What would you recommend to provide the optimum support for paramedics and other people working in Ambulance Tasmania?

Mr WALLACE - If we were to do what the recommendations should be to get out and supervise staff more, we would have to reduce some of the other, even miniscule tasks like administrations. I still sign timesheets. The analogy I use is the toilet paper, I still order the toilet paper, I still have to get all the trucks sorted. There's lots of support areas. Our operations manager at the moment is still doing the pays, which is like 20 hours of work.

CHAIR - Separating the administrative and the operational from the clinical and the emotional and mentoring support?

Mr WALLACE - That would be great, that would really help me.

CHAIR - Help you as a manager?

Mr WALLACE - Yes, as manager and dealing with some of the workload. Historically it's always been you ring the duty manager, but that's got busier and busier. There's a process called the daily desk, which was implemented so that people call, which is great. They do all the day-to-day rostering for today and tomorrow. That cuts out some of my work, but when that hasn't been staffed, one day I received 86 phone calls in one day, about one every eight minutes. How on earth can I do my job and do that. It's positive that we've got it, but just when it wasn't staffed the work goes through the roof.

I believe that ambulance services are looking at part of that as positions, they're looking toward the Government, on-road staff, support staff, admin staff. That would help.

CHAIR - That would take some of your duties away from you, that could free you up.

Mr WALLACE - To go and see if they're okay.

CHAIR - How many people are you responsible for?

Mr WALLACE - On a day shift there would be five crews. I'd have to work it out, but basically, it's the day-to-day operations in the northern region. But we do have other managers but it's the day to day, anything operational. We might have five urban crews in Launceston plus all the branch stations. We do have branch station team leaders who provide some support, but the phone comes to us.

CHAIR - For the northern region?

Mr WALLACE- For the northern region for the day-to-day operations. For the night shift, I'm the supervisor for all those branches.

CHAIR - Including the toilet paper purchases.

Mr WALLACE - Including the toilet paper.

CHAIR - Thank you so much, Hamish, your evidence is invaluable to us. It really makes a difference to hear the actual voices of people who are working and doing this job every day.

We thank you for coming all the way down and for being so comprehensive in what you've told us.

Mr WALLACE - Hopefully I was clear.

CHAIR - Very clear. Before you leave, I want to remind you of what I said at the beginning which is you've been covered by parliamentary privilege and everything you've told us here today, when you leave the parliamentary privilege doesn't follow you, just remember if you make comments about what you said today.

Mr WALLACE - I understand.

THE WITNESS WITHDREW.

The Committee suspended at 2.53 p.m.

The Committee resumed at 3.00 p.m.

CHAIR - Thanks for coming today. I want to take you through the information that the secretary should have given you. This is a committee of parliament and in order for us to be able to do our work and get the best information possible, you are covered today under parliamentary privilege so that anything you say in here, you can say with freedom that you won't be sued or taken to court for what you say. But that doesn't cover you when you leave the room. Even though you might say some of the same things you said in here, if they could be defamatory, if you say them outside, you're not covered by parliamentary privilege. Do you understand?

Ms VAN TIENEN - Yes.

Mr JACKSON - Yes.

Ms ELLA VAN TIENEN, STATE MANAGER, PHARMACEUTICAL SOCIETY OF AUSTRALIA, AND **Mr SHANE JACKSON**, NATIONAL BOARD MEMBER, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - We've got your submission. Thank you very much. Would you like to start with any opening comments or a statement?

Mr JACKSON - Thank you, Chair. I'll open by saying that we know that ambulance ramping, we know that emergency department delays and challenges in timeliness of people being seen has been a long-term issue, perhaps becoming increasingly evident over time. What we would like to highlight is that not only the pharmacy profession, but pharmacists on the ground and other primary-care providers have an opportunity to not necessarily solve the problem but be part of the solution. I will probably, in this opening statement, concentrate on pharmacy.

Pharmacy is, in my view and the view of most of the other pharmacists in the profession, the most under-utilised health professional workforce across the country, and probably internationally. We have an opportunity as pharmacists to be able to do more for patients. We have an opportunity to be able to lift what we do so that more patients can be seen. We can do more for patients so they're not necessarily presenting to general practice, to free up GP appointments and those GPs can see patients who might ordinarily end up in the emergency department.

In our view, it's about all health professionals lifting their scope, not being placed in handcuffs in what they can do. Their handcuffs should be their training, not legislative impediments that allow them to practise to full scope.

What we would like to see, and what we think is part of the solution, is that pharmacists can do more across the state. Pharmacists can treat more patients, pharmacists can free up more GP appointments and pharmacists can do that in a safe way that allows patients to be kept out of the emergency departments and free up emergency departments for emergencies, not necessarily just acute care.

CHAIR - I understand that the pharmacy scope of practice is something that is ongoing work between the Pharmacy Guild, RACGP and other stakeholder organisations. It's not

directly something we are focusing on in our inquiry. But we understand that ramping is not just about what happens on the ramp; it's whole-of-system pressures, and preventative health is a critical part of that. We're alive to the importance of keeping people well and treating people in the community so they don't get to a situation where they need to call an ambulance in the first place and go to hospital.

We could talk about a number of things in your submission, but one of the things I'd like to start with is pharmacists within the hospital and the connection between the emergency department and the ambulance ramp, the small connection between the pharmacist dispensing medications and what happens in terms of provision of care and treatment for patients on the ramp and in the emergency department. Can you please give your view on how well you think that connection goes and the relationship, and whether you think that there are gaps and room for improvement?

Mr JACKSON - Ella, you might be able to comment on that first.

Ms VAN TIENEN - I'm not really over what happens to the patients who are still in the ambulances themselves. But I'm aware that once patients are within the emergency department the pharmacists can chart medications which then enables them to be supplied by the hospital through administration.

Currently, the pharmacists have a conversation with the doctor, whoever is in charge of that person, before they chart the medications, but there still needs to be a signature before that's a legal order. That's an impediment that could be removed because the conversation has taken place, and the pharmacists do the medication reconciliation far more accurately - usually - than doctors do. Studies suggest they have the contacts with the other pharmacies and ask the right questions to get the right medication histories. I'm not entirely sure how it works out into the actual ambulances on the ramps.

CHAIR - Okay. What about the move being discussed at the moment towards 24-hour admissions and 24-hour discharges at the Royal Hobart Hospital? We would hope and expect that should be across the major hospitals of Tasmania. How do you think that would work for pharmacists and the provision of medications? Because being able to get the medications when you leave or discharge is obviously very important.

Ms VAN TIENEN - There is not currently, to my knowledge, a 24-7 pharmacy service. There are pharmacists on call during the night, but the emergency department initially was staffed extended hours by pharmacists. I don't believe they're there throughout the night. I think they leave at 9 p.m. or 10 p.m. and creates an issue.

Mr JACKSON - And that would also create challenges of clinical handover. Patients who take a large number of medications, patients with chronic disease, the pharmacy department and individual pharmacists are very proactive in making sure there is a clinical handover to the patient's community pharmacy. That's done quite effectively. There's often a phone call made and there is written information provided to the patient's community pharmacy who's looking after that individual -

CHAIR - Sorry to interrupt, is that done every time? Is that a guaranteed thing that always happens?

Mr JACKSON - It would be rare nowadays for a patient who has a regular community pharmacy for that community pharmacy not to be contacted, especially whereby that pharmacy is providing the person with administrative support for their medicine, like a medication pack, for example. The pharmacy is quite proactive in making sure the community pharmacy is well aware of the changes being made to a person's regime.

CHAIR - Would it be the case that a patient, when leaving hospital, would be asked - presumably by the nurse in the ward - 'Who is your community pharmacy?', and then there would be a process that would go through that?

Mr JACKSON - Yes, that is normally a role taken on by the ward pharmacist. They would normally coordinate that and communicate actively with the patient's community pharmacy, about any changes that have been made. In terms of 24-hour care, that would be quite difficult.

CHAIR - Would that be an impediment to moving to a 24-hour system then if there's not a pharmacy to call for supplies available and discharge? How is that going to be resolved?

Mr JACKSON - That would be an issue for some patients, especially where that community pharmacy is actively managing that person's medicines.

Ms VAN TIENEN - Are you talking about 24/7 discharge from all wards or just from the emergency department?

CHAIR - I believe the idea is from everywhere.

Ms VAN TIENEN - The people who mostly would have this service are ones who've been admitted and then there are changes to their medications. Generally, unless something was changed in emergency, we may not know that somebody's been to emergency, so it wouldn't be such an issue. For emergency, what I can see is benefit to 24/7 pharmacy services. In the emergency context is that people who come in have a few hours in emergency but are then fine to go home, but they needed medication. If you send them home in the middle of the night, they don't have that. It might be pain relief or antibiotics they need to continue to take, so those things really would benefit from a bigger pharmacy service.

CHAIR - Do the major hospitals not have that service available?

Ms VAN TIENEN - They would have the regular things on Imprest that they could provide. But there would be things that would be needed sometimes, that the person would either then have to obtain the next day or the pharmacist would need to be called in to supply if it was urgent. There would be things on Imprest in the emergency department for discharge for some patients, but it would depend on what their medication was.

CHAIR - On Imprest?

Ms VAN TIENEN - It is like a storage cupboard in the -

CHAIR - Of available medications for emergency department staff?

Ms VAN TIENEN - Yes, that could be supplied.

CHAIR - If you are trying to prevent people from coming back to emergency, then having people go home with the right medications would one useful thing to tick off to make sure that you are doing as much as possible. Currently there is not that service, other than on the Imprest?

Ms VAN TIENEN - Yes. The Imprest should cover the majority of things but there will be things that would not be available on Imprest. If you were extending it to, not just those really acute care situations, there might be people in a short stay unit or something who then get discharged. Then, the breadth of medications would not currently be available, necessarily.

CHAIR - Are you aware of 24/7 pharmaceutical services available in other hospitals, in other states?

Ms DOW - Are you familiar with them?

Mr JACKSON - I am familiar with them, yes.

Ms VAN TIENEN - It would be available in larger pharmacies, like larger hospitals in bigger states.

Ms DOW - Thanks to you both for coming in and presenting to our committee. I just had a question for you around access to 24-hour community pharmacies. I know in your submission you refer to the Government's funding grant that they provided to pharmacies with the after-hours advice line and how that has since concluded. Do you know why? And obviously, you think that it would be beneficial for that to be continued.

A number of other states across the country - South Australia, in particular - their state governments have funded 24-hour access in community pharmacies as a way of reducing the burden on emergency departments after hours. I wondered what your thoughts are on that and whether you think there is merit in it, and whether you can put some remarks on the record?

Mr JACKSON - I will comment on the second part of the question first. Yes, other states have funded 24-hour pharmacies, which in our view, makes sense. A number of years ago - maybe two or three - the state Government funded pharmacies to open in the after-hours period, so to extend their hours. A number of pharmacies were open until about 10 or 11 o'clock, that was some short-term funding that was provided for about 12 to 14 months. Then, the grant guidelines were changed, and no pharmacies were provided with ongoing funding. Our view is that the Government should look at supporting existing infrastructure to extend hours, whether that extends to 24 hours or whether that extends to more hours. We think that is a wise consideration, because sometimes access to medicines is a reason that people present to emergency departments. Sometimes, it is just access to a health professional.

My pharmacy was one of those pharmacies that received some funding in the initial rounds. We found that 50 per cent of the presentations in the extended after-hours period was just for health advice. It was not necessarily for a medicine. With our provision of health advice, there was no remuneration to the pharmacy, because you are providing advice and it is not customary to charge necessarily for advice. But that existing funding that was present at that time allowed our pharmacy and a number of other pharmacies to be able to provide that.

We had data that showed about 7 per cent of the people who presented in that after-hours period, when we asked them, would have gone to the emergency department.

That is backed up by interstate evidence about what those pharmacies have done in the after-hours period when supported to be able to open and serve me in the context of the 24-hour pharmacies that have often been supported to have a nurse practitioner in those after-hours periods as well. That is a wise consideration - and we are quite firm about this - to look at supporting existing infrastructure. That does not just extend to community pharmacies as well. It's supporting the existing general practice services to potentially extend their hours instead of necessarily making decisions where you're creating new infrastructure. You already have existing infrastructure that can be supported to do more, because most practitioners want to be able to do more, they just want to be able to do it in a supported way and a way that doesn't necessarily cost them to deliver care.

Ms VAN TIENEN - I think the other question was about the advice line. We had funding to run that for eight months in total. There were people who avoided going to emergency having phoned that line. One person was triaged to emergency who said they would have stayed at home had they not phoned the advice line, and they required pretty serious intervention.

We had Healthdirect and GP Assist referring people to the line, so we were quite disappointed when there wasn't an opportunity for ongoing funding. As Shane said, a lot of people just want health advice. They want to be reassured that actually they're fine to keep caring for their sick child at home, or this medication is the appropriate one to use in this instance. Some of those people would go to hospital if they can't access that advice. Overall, the cost of manning a phone line for a few hours in the evening isn't significant compared to what it might cost if they present to emergency unnecessarily.

CHAIR - What was the reason for not continuing it?

Ms VAN TIENEN - It was part of the primary grant program. So, it was a 12-month funding package.

CHAIR - Federal?

Ms VAN TIENEN - No, state.

CHAIR - What was the reason for not continuing that?

Ms VAN TIENEN - The next grant round had different eligibility criteria, so we weren't eligible to apply for ongoing funding, and there was never the offer to continue.

CHAIR - What date was that trial run, what year? 2017 or something?

Ms VAN TIENEN - No, it was more recently than that. December 2022 to June 2023.

CHAIR - So, there was just a change to the criteria, but it was something that has been raised. It's not just in the health area, it's across other areas. The use of trials can be very problematic because good ideas are demonstrated to be good ideas and then there's no follow-up.

Ms VAN TIENEN - We felt it was tricky too, because we would have done more marketing and had better numbers except we were not confident we were going to get ongoing funding. We didn't want to make it standard practice for the disability care, for the aged care and for consumers to be calling the line and then have it taken away, which is exactly what happened. I think the numbers would have been even better if we'd known the funding would be ongoing, because we could have done more marketing, but we didn't feel it was ethical to do more marketing and know it was going to probably stop.

CHAIR - Can you talk more about the people who were ringing aged care and disability care in particular?

Ms VAN TIENEN - Disability care in particular, because they often have episodes where they're not sure what to do with their client's medicine. The support workers who aren't able to make decisions on their own, or they might have a client who has a symptom and they've got a range of things charted but they don't know the most appropriate thing to give them in that instance. We had a lot of calls from them, and a lot of calls from the public asking general questions.

The lady I mentioned before was from your area, and she was having symptoms that were suggestive of an anaphylactic reaction, but she didn't want to call the ambulance. Then the pharmacist was saying, 'We're going to put you through to the ambulance', and got them to contact Healthdirect. They went to the ambulance, they went to emergency, and that's where they needed to be. Her follow-up feedback just said, 'I wouldn't have called the ambulance and then I would have probably died at home on my own if I hadn't called this service'. So that was scary. Most people were just satisfied that they had helpful advice.

CHAIR - Did you find that people from aged care homes were ringing?

Ms VAN TIENEN - Yes, from a couple, as I said, I didn't push it too hard because I didn't want to embed it in their practices. But there were a few aged care facilities who did take it on board, and they would ring. Many of them now, the RNs go home at 5 o'clock or 7 o'clock, and then in the evenings they wanted to know when required meds were appropriate or if the person had been out and missed their 6 p.m. medication, is it okay to give it at 9 p.m., but they didn't have anyone else to call so they called this line to ask.

CHAIR - So, there were 523 calls over an eight-month period. Who was staffing the other end?

Ms VAN TIENEN - A pharmacist.

CHAIR - A professional pharmacist, one single person?

Ms VAN TIENEN - There was a roster of pharmacists, but there was one pharmacist rostered on every evening.

Ms DOW - Around rural and remote Tasmanians, in your submission you talk about the importance of regional pharmacists and remote pharmacists providing telehealth appointments. Do you have a breakdown of where that is happening currently across Tasmania, how many

pharmacies are doing that and the potential for more to do that, given funding and the appropriate infrastructure being provided?

Ms VAN TIENEN - I don't have any specific examples. I'm not sure if you do. But something I think would be very beneficial, having worked weekends in rural pharmacies where you end up facilitating conversations with Healthdirect GPs, that could be done via a video link. The person that springs to mind is someone who came into Shane's pharmacy many years ago when I was working. It was an elderly lady with dementia who clearly had a shingles rash across her face, and she was unable to talk to the doctors, so that was a conversation I needed to facilitate. Had there been a video screen, he would have been able to see that quite clearly as well. There is plenty of opportunity for that to take place, but no remuneration.

Mr JACKSON - I will give you an example. I have a pharmacy, as you know, Anita, down at Nubeena and it is just not financially viable for us over wintertime to open on a Saturday. It is as simple as that. We open on a Saturday from December through to about March/April as there is a higher population there and there is generally more acute need on a Saturday morning to open.

When we had the rural after-hours grant we opened Saturday mornings. On top of that, we developed a relationship with the local GP. We already had a relationship, but just as an example, we said to the local GPs, 'we are now open on Saturdays', and one of the GPs said, 'I am happy if you just give me a call and I will do telehealth because you are open'. So, we would generally make four to five calls every Saturday morning to the GP. We didn't have any remuneration for that but that was okay because we were supported to open. It did not worry us one little bit and those four to five people got access to care. That was important from our point of view. Then the funding wrapped up, so we are unable to deliver that.

We'd go back to delivering that in a heartbeat if we could, but we can't. There are examples of those types of things. And if we had the support from an infrastructure point of view, you could set up a little telehealth, we have got in our pharmacy down here three consult rooms. We set up one of those rooms to have a little screen in the corner to be able to dial into whether it is the local GP or whether it is GP Assist, so that they can see the person if necessary as well.

I think community pharmacies in rural Tasmania, often those rural practitioners, are innovative, they are well connected to their communities, and they are well connected to their patients. They want to be able to do more. We have just got to make sure it is not costing them to do.

CHAIR - How did that get paid for?

Mr JACKSON - We were able to cover that because we had a small stipend that covered the salaries of our staff that worked on the Saturday morning. That was it, that was all I wanted, as in I just did not want it to cost me to be able to open. So, that is what we did, and we were happy to do anything that the community needed us to do because we were supported to open. In terms of those types of things, the Government can look at supporting the workforce and they can look at some of those things, supporting infrastructure, to be able to connect.

A lot of those rural patients would not know about GP Assist, they have no idea. What they know is that, 'if I have got something wrong with me, I go to the most accessible provider

of care'. Sometimes that is the GP and a lot of the time that is the community pharmacy. The community pharmacy can then assess somebody and link them up. But what we must acknowledge is that, because of Commonwealth Government decisions, there is no support for pharmacy to do that. In the absence of support and given the downstream impacts, the state Government probably needs to look at that. And they have done, but they have only done it in short periods of time. Some of these have been quite successful. We would hope that they would look at that again to reduce some of these other impacts in the healthcare system.

CHAIR - The Pharmacist Scope of Practice report looked at collaborative prescribing, which you argue could have positive benefits for people in aged care, in particular, or older Tasmanians. Can you talk about the reduction in psychotropic medications, chemical restraints? Is that for people in aged-care homes?

Ms VAN TIENEN - Primarily. Studies have shown - our organisation commissioned a report into medicine safety in aged care a few years ago. Essentially, what they found, looking at the research, is that there are significant reductions in the use of chemical restraint and psychotropic medications when you have pharmacists more involved in the care of older people, particularly in residential care. There has been talk for a long time of embedding pharmacists within the aged-care team and we might finally be getting to that after a few years of federal funding discussions. But even having them embedded in the team, the state still controls the legislative instrument that enables prescribing to take place.

The argument would be that, within a care team, in agreeance with the doctor, whoever is looking after that person, the pharmacist could adjust the medications in alignment with their treatment plan. Some people have GPs who are fantastic and have multiple residents that live in the same facility, and they come to the facility all the time. But some residents' GPs don't visit from six months to the next and so really aren't connected to their care, don't know what is happening. Sometimes they refer them for a medication review but, in my experience, those GPs don't tend to even respond to the report, let alone take our advice on board if we give some. We know that one in five people in an aged-care facility are at risk of having a medication misadventure that lands them in hospital. If we can reduce even a fraction of that, that takes more pressure off the emergency department as well.

CHAIR - So, it's talking about stepping into the diagnostic space.

Ms VAN TIENEN - Not so much diagnostic. I think diagnostic still sits with the doctor, but then the doctor says, 'This person has blood pressure issues and we want to maintain their blood pressure within this range. They don't have any allergies. Prescribe them the most appropriate thing, adjust their dose, get their blood pressure under control'. The same for a range of other chronic conditions.

CHAIR - It's about monitoring how they are responding so that they don't go outside safe ranges or have unintended adverse consequences.

Ms VAN TIENEN - Yes, that's right.

Mr JACKSON - It's more about medicines optimisation than diagnostics and treatment, so making sure that if we've got a treatment plan, how we are achieving that treatment plan.

CHAIR - Michelle, did you have any questions, or Simon?

Ms O'BYRNE - Apologies. My IT is a bit dodgy so I'll refrain from questions at the moment.

Mr BEHRAKIS - On the successful pilot that you all talked about earlier, the one that was supported by the state grant, have you guys gone to the federal government at all for any sort of longer-term funding of that?

Ms VAN TIENEN - For the opening hours or the phone line?

Mr BEHRAKIS - The phone line.

Ms VAN TIENEN - I believe there are some discussions with Healthdirect around the potential for a pharmacist to be embedded in the national Healthdirect phone line, but that's not moving quickly.

CHAIR - I can't understand why not. It's such an important resource.

Ms VAN TIENEN - It may happen but I know that the person who was working with me from our national office on this team was pitching this to Healthdirect before this project had finished and it's been many months since this project finished now. We haven't seen anything come to fruition from that, I guess.

Ms DOW - As far as the scope of practice review goes, and our Chair alluded to that at the beginning of our session with you, how is that progressing? Are there additional things that are going to be progressed in the short-term and any feedback on that process and how it could be improved? Where do you think there are changes to the scope of practice of pharmacists that really should be a priority for the state government?

Ms VAN TIENEN - Changes are imminent. They should have already happened, but I believe probably the first thing will happen on 1 March. Today or tomorrow, correspondence is supposed to be going out to pharmacists around the ability for pharmacists to prescribe antibiotics in accordance with a treatment plan for uncomplicated urinary tract infections. Initially that was to start at the start of the year, but I believe the start date is now going to be 1 March, so that's happening.

From there, it hasn't been made clear yet what the next step or priority is. There is a steering committee and an implementation group set up within the Health department, so they now have a team of two. One of those is Duncan McKenzie, who you may be aware used to be the clinical adviser to the Minister for Health, so he's been called into the department to lead the scope. I think it is called the Pharmacy Project Work, so that's great and he now has a second person assisting him, but it's slow work and I don't know what the next priority for implementation will be.

In some of the other states, they have moved from UTI to prescribing for skin conditions, expanding travel health, ongoing supply of oral contraceptives, which we already kind of can do here through our continued dispensing arrangements, which are more broad than other states.

CHAIR - So, there can be an extension of one supply?

Ms VAN TIENEN - Yes, one supply - three to four months' worth, which is -

CHAIR - So, what are the next things? You said expanding travel health?

Ms VAN TIENEN - I'm not sure what our priorities are, but in other states, that's what they have done: travel health; skin conditions - treating cellulitis - and oral contraceptives, which we kind of have here.

The other things that were spoken about were looking at the prescribing within aged care or having a pharmacist within a general practice environment to assist with medicines optimisation for patients under the care of a GP within the practice to take pressure off the GPs. And then the hub-and-spoke model for the rural patients, which is less clear how that's going to work; that may also be something that comes up in the near future. The group itself hasn't outlined what the next thing that will happen after the UTI.

Ms DOW - What's your priority, as an advocacy group, to be the next thing to be implemented?

Mr JACKSON - From our point of view, we believe that acute care - as acute care in primary care - is the most important priority, because that is what patients are struggling to get access to in primary care. For example, seeing their GP in a timely way and then if they can't see their GP, where do they go?

What we believe is that it is community pharmacy prescribing of things that need acute treatment, and we are not talking about trying to expand the scope to what GPs do. What we are saying is that if you have an appropriate environment that has consulting rooms, the appropriate infrastructure in terms of quality assurance and the appropriate people, in terms of training, then you should be able to do the things that you can do in that environment and by those individuals. This might take us a little bit of time and it also takes a strategy, and it takes investment.

If I look at what's happening in terms of the north Queensland pilot, then our pharmacists are doing a graduate certificate in terms of limited diagnostic capabilities and prescribing capabilities that match up those diagnostic capabilities. So that's about ensuring that patients have access to the acute care when they need to and not just saying that they get their treatment. But they might also get the referral that they need to as well. That's pharmacists working within their scope and it's pharmacists prescribing within their scope.

That's going to make the biggest difference for Tasmanian patients and probably make the biggest difference in terms of the Tasmanian pharmacist workforce. There is no reason we can't train those pharmacists here in partnership with the University of Tasmania and also have them expanding that scope gradually over time in collaboration with general practice - not in competition - in collaboration. Then, we have an opportunity to work on some of these more collaborative prescribing models in aged care and other settings. That will make the biggest difference for patients, utilising the 145 pharmacies or so that we have in this state. To get them to lift and to lift underneath general practice, which is struggling under the strain at the moment.

CHAIR - They would be covered by Medicare, those services?

Mr JACKSON - If we look at what is happening in other states, it has largely been a user pays model initially.

CHAIR - Moving towards Medicare would be the aim?

Mr JACKSON - You would hope that there is some Commonwealth recognition that this is something that needs to be paid for given that they are responsible for primary care. All we are saying here is that our state Government needs to move the legislative impediments - because that is what they are responsible for - to allow pharmacists to do that.

CHAIR - These would be things, acute primary care that would have a pharmaceutical response?

Mr JACKSON - Yes. A couple of additional examples are a shingles presentation. Some shingles are easy to diagnose; some shingles are less easy to diagnose. The important thing is that a patient gets treatment as soon as possible with the anti-viral. Nausea and vomiting, for example, are associated with gastrointestinal illness. I believe in north Queensland there are about 18 acute presentations that have been modelled on international acute care treatments that have been safe and effective in community pharmacy that a patient has struggled to get access for. I don't know a general practice that can guarantee same-day appointments or within two-day appointments or within a week appointment. There are patients who are going untreated and potentially having adverse outcomes through that.

It is about pharmacy lifting. Pharmacy lifting to be able to support general practice, not in competition with general practice at all.

CHAIR - Okay. I believe we are nearly out of time. Is there anything else that you would like to say to us? Ella?

Ms VAN TIENEN - I believe we may possibly have the legislative instrument in place at the moment to enable that to take place. It is just that it has a six-month time cap on it.

CHAIR - Time cap on it? What do you mean?

Ms VAN TIENEN - For the thing, the part of the legislation has an expiry date in six months.

CHAIR - Oh. What act is that?

Ms VAN TIENEN - It is the Poisons Act. It is this bit that is an interim authorisation order. It would enable pharmacists to prescribe under a protocol-driven model that the department has published. At this point in time, it is broad enough that any condition that Shane or others alluded to - if there was a protocol written and published by the department, pharmacists did the appropriate training, then they would be able to prescribe under that model -

CHAIR - As long as there was a treatment plan that had been provided by a medical practitioner?

Ms VAN TIENEN - It is an 'or'. It is either for an individual patient with a treatment plan or it is a specified condition with a protocol-driven prescribing for something that is published by the department.

CHAIR - Right.

Ms VAN TIENEN - For the next few months, that is possible.

CHAIR - Okay, does that cover the UTIs issue?

Ms VAN TIENEN - Yes, that has been put in place for the UTIs.

CHAIR - All right, so that will expire -

Ms VAN TIENEN - In less than six months.

CHAIR - This is a regulation that has been made though?

Ms VAN TIENEN - Yes.

CHAIR - That can be remade?

Ms VAN TIENEN - Yes.

CHAIR - It is not an issue?

Ms VAN TIENEN - No, we are not expecting it to be an issue -

CHAIR - It is not an impediment? No? Okay.

Ms VAN TIENEN - Not currently, the environment currently exists. We just need to keep pushing to get more things added.

CHAIR - There is no reason to think that will not happen though?

Ms VAN TIENEN - No. Not at this point in time.

CHAIR - Good. All right, well, thank you so much for appearing today. It is really helpful to have your view because it is another part of the puzzle of the whole-of-system approach that we need to take to look at this issue. We are keen to look at short- and medium- as well as long-term recommendations. That is part of our committee's work.

I just want to remind you both that when you go outside you are no longer going to be covered by parliamentary privilege. Please bear that in mind if you make any statements that could be defamatory. I do not think there is anything that you said today that would fall in that category.

THE WITNESSES WITHDREW.

The committee adjourned at 3.40 p.m.