PUBLIC

THE HOUSE OF ASSEMBLY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART ON THURSDAY 14 DECEMBER 2023

The Committee resumed at 12.34 p.m.

Ms EMILY SHEPHERD, BRANCH SECRETARY, **Mr JAMES LLOYD** AND **Ms KYLIE STUBBS**, AUSTRALIAN NURSING AND MIDWIFERY FOUNDATION (TAS) WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome. Thanks for coming all this way across Hobart for James. Just before we start, I want to ask you whether you got the advice given by Fiona, the secretary of the committee, the guide that she sent about parliamentary privilege?

All Witnesses - Yes.

CHAIR - I want to reiterate a couple of points about that. This is a committee of parliament and so that we can do our work really thoroughly you are covered today by parliamentary privilege. That's a legal protection that means that anything that you say here can be given with freedom and without any fear of being sued or any other legal actions taken against you. You need to understand that this protection just stays for while you are in this room giving evidence to the committee. When you walk outside, even if you say the same things, you're not covered by parliamentary privilege. It's a public hearing today, so there could be journalists and members of the public listening to what we say. Your evidence can be reported. I don't think it's the case for the ANMF, but if there is anything you want to add to the committee in private, we can organise, if you let me know, to make part of the hearing confidential, do you understand.

WITNESSES - Yes.

CHAIR - Did you want to all start off by making a statement? We have all got your submission and we've read it, and I've seen you've also put out another media release today. Is there anything you want to start off by talking about?

Ms SHEPHERD - Yes, just a brief statement to begin. Thank you for the opportunity to provide our submission and meet today with the committee in relation to this issue, which is obviously quite a significant issue for our members across the state, particularly for those members working in the emergency department, but moreover across the entire health system.

Obviously, the complex issue of ambulance ramping, or transfer-of-care delay - I absolutely mean no disrespect when I talk about ambulance ramping; but that is how it's characterised by our members and personally, knowing some paramedics, that's also how they characterise it. I don't mean any disrespect. I appreciate those patients ramped are being cared for by health professionals and very experienced ones at that - in terms of being cared for by a paramedic. Certainly, ambulance ramping is one of the key issues our members have raised with the ANMF for many years, right across the state.

We have members at the Royal Hobart Hospital, the Launceston General Hospital, the Mersey Community Hospital and North West Regional Hospital with their emergency

departments. I'd have to say from probably 2016-17 onwards we've seen significant increases in concerns from our 18 members in relation to access and flow challenges out of the emergency department, and also including increases in ambulance ramping.

In 2016-17, we would have only probably seen that concern raised consistently from members of the Royal Hobart Hospital. We're now seeing that concern extend around 2018 to the Launceston General Hospital, where they commenced a two-year campaign with our members in the emergency department, primarily because of access and flow issues. That industrial campaign was titled Bring Your Own Bed, where our members campaigned on Charles Street outside of the hospital for well over a year - rain, hail or shine every day - to call on the government to put additional resources into that emergency department, because of workloads and also safety risks for themselves, but more importantly for their patients in that department.

That resulted in an additional 21.3 full-time equivalent nurses and midwifes eventually being agreed to by the Department of Health to be put into that emergency department. Our view at the time was solely because of access and flow challenges, it was acknowledged by the ANMF at the time that if access and flow out of that emergency department was actually occurring, that additional staffing compliment would have likely not have been required, but was required in the context of access of flow challenges, and of course, ambulance ramping.

Of course, we've now seen that extend in subsequent years to the North West Regional Hospital, although not at the same level as at the Launceston General Hospital and Royal Hobart Hospital. Of course it is concerning that pattern is increasing, and we've had instances at the Mersey Community Hospital as well.

I know you have questions, so I will come to a close in terms of a brief opening statement. I guess the main point from the ANMF is that we can't look at transfer of care and ambulance ramping in isolation. Ambulance ramping and transfer-of-care delays are obviously a consequence of the broader, fundamental issue of access and flow challenges right across our hospitals and the health system. We are very concerned that there are moves afoot to see that there will be the mandatory offload of patients within 60 minutes in our emergency departments, when the work of this committee and also the review by the Department of Health into major hospital emergency departments, those works and recommendations, have not yet been completed. Because our view is that that really is just transferring the risk of those patients from an ambulance stretcher into an overcrowded, over-capacity emergency department.

What's more, whilst they are on the ramp, they are being cared for, as I alluded to before, by a health professional - albeit I appreciate that isn't the role of paramedics to be caring for patients in the emergency department on the ramp; they should be in the community responding to 000 calls. But putting a patient into an overcrowded, over-capacity emergency department is not the answer either.

I will probably leave it there in terms of opening statement on behalf of the ANMF and members. Did either of you want to make some opening remarks?

Mr LLOYD - I am happy to make some brief remarks. As you know, I am the Tasmanian branch president, but my role in health is I am an after-hours nurse manager or patient-flow manager, essentially. My role in the system is to basically allocate beds to people

within the hospital. I have been doing that for 13-plus years, so I have this really unique perspective on this end.

It is true what Emily was saying before - until about 2016 to 2017, ramping wasn't such a massive problem, but then suddenly it started becoming a problem. That is because of the increasing demand for healthcare services, because people are getting older, the baby boomers are coming through.

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

CHAIR - Thank you. Kylie, did you want to say anything?

Ms STUBBS - Not at this point. I will state what I have to say when we get further through the process.

CHAIR - Okay. Thanks. Just going back to the causes, I am interested in a little bit more detail. You said you have 21.4 nurses, I think it was, that have been added into the Launceston General Hospital emergency department after that action. From what you said, that's a stop-gap measure essentially; it's not in any way dealing with what James has said is a fundamental, overall problem. Do you want to talk about some more of the causes, and issues like nursing ratios, staffing ratios and the availability of nursing staff in other parts of the hospital to be able to move people efficiently through as well as care for people?

Ms SHEPHERD - Sure. Obviously, as I said, we called for that 21.3 FTE additional to the benchmarked FTE that was required under the benchmarking model, which really looks at the presentations per day, effectively, which would then guide the staffing profile for those emergency departments. Clearly, in the context of access and flow difficulties, what we see is the overcrowding and over-capacity of emergency departments, which is a mixture of admitted patients who are requiring in-patient beds that can't be moved out of the emergency department; you then have those patients within the emergency department who have been triaged and allocated to a bed; and then of course you have that patient cohort in the waiting room that is waiting to be seen. In addition, you then have those patients who are ramped, albeit we know that from a nursing perspective there is often investigations carried out where those patients might be escorted from the ramp to go and have a CT and then escorted back to the ramp by a nurse.

In the context of access and flow, in an ideal world people would come into the waiting room in the emergency department, they'd be triaged, allocated a bed and within four hours you would either be discharged home or you would be admitted to an in-patient bed and moved out of the emergency department. We know that this isn't happening. We've got some of the worst wait times in the country, particularly at the LGH. As James said, the issue around that

is multifactorial in terms of the causes, predominantly because we know that patients aren't all one capacity, and I don't mean this in a derogatory way, but of course the demand is increasing. We do have an older population with multiple chronic diseases, so demand and the complexity of patient presentations is also increasing over time as well.

We also know that there is a cohort of patients who are admitted through the emergency department who have longer stays than others, which those might be who require aged care placement to post discharge, may not have had any ACAP processes undertaken prior to admission. It might be they present with a fall and then a decision is made for us to transfer to residential care. Increasingly, the numbers of those patients who are receiving NDIS support who might need alternate living arrangements on discharge are also causing significant delays in terms of discharge. What that means is when we have cohorts of patients who aren't moving out, as James said, in a timely way to discharge. At the other end we've got increasing presentations and a bottleneck effectively of people not being able to move out of the emergency department. It's just a perpetual cycle.

Some of the other system issues that contribute to access and flow from an ANMF perspective are that a lot of the services and supportive services to healthcare delivery are staffed to business hours. So we know in terms of radiology, pathology, they're business hours. If we want to be able to move people out of the emergency department, we really need to be able to ensure those patients can get their investigations and pathology, radiology, et cetera, in a timely way so they can have a definitive diagnosis and either be admitted or discharged.

CHAIR - There is a 24/7 radiology and pathology at the Royal -

Mr LLOYD - Yes, there is.

CHAIR - But not at the LGH?

Ms STUBBS - Not at the LGH.

CHAIR - And not at the North West or the Mersey. Is that correct?

Ms STUBBS - Yes, there's an on-call service, but there's not somebody on site 24 hours.

CHAIR - Does that make a difference to people who are listening? If someone's on-call isn't that good enough?

Ms STUBBS - No, because I think to have somebody there on site, it would be more timely that they receive those diagnostic assessments. That is something that we definitely need to advocate for, to have somebody on site.

Ms SHEPHERD - Also to have a lot of those investigations delayed so that somebody is not being called in for one patient. So we know you need a CT, but we'll just delay that because we think this person over here might need one, so we'll just wait until we've got a few CTs so that it's worth our while to call the on-call in and do them all in a group.

CHAIR - Is it the case that there's now triage-by-diagnostics happening? We've heard from other people that the triage process is essentially not completed until a diagnostic has been returned, in which case a patient is still in the care of a paramedic - they're not under the care

of the ED and so they're not even actually triaged at that point until they get diagnostics. Why isn't there any triage happening on the basis of the presentation?

Ms SHEPHERD - Because once a patient's triaged the transfer of responsibility and accountability for the patient is transferred to the emergency department so, effectively, once that occurs and they're triaged, they then become a patient of the emergency department. The difficulty with a ramped patient is that means a paramedic goes off to be a paramedic and that patient has to be allocated a bed space. Until there's actually an appropriate cubicle or bed space for that patient to go, then it's very difficult to triage a patient and then say -

Ms STUBBS - Just sit in the waiting room.

CHAIR - Have you been advocating for increased bed space and extra nursing in order to be able to relieve the situation of people being stuck on the ramp for so long?

Ms SHEPHERD - We don't necessarily see that as an appropriate solution to have additional nursing staff caring for patients on the ramp because part of the issue that we've seen -

CHAIR - I wasn't suggesting on the ramp; I was suggesting off the ramp and having more nursing staff so that paramedics could be relieved to go back to being paramedics and patients could be triaged under the care of nurses in additional space.

Ms SHEPHERD - The difficulty is that there isn't additional space. If there was additional space, the patients, presumably, wouldn't be ramped in the first place. They could be triaged and allocated a cubicle bed space. They wouldn't be on the ramp.

CHAIR - Is there a room at the Royal Hobart Hospital that paramedics use as the ramp room, and why would that not be a nursing room, for example?

Mr LLOYD - Yes, there is an area behind the ED where ramped patients who are under the care of paramedics can go and the reason that is not staffed by nurses is because we don't have enough nurses to do it. Basically, in there we do not have enough resources. I've talked about physical resources, like beds, but we also have human resources like nurses and staff who we just have to do that. That's one of the issues because all the nurses around the main ED are trying to take care of everyone around the main ED.

Ms SHEPHERD - And it is not as simple as saying - we've got the space and we just need some more nurses and, therefore, they can be offloaded and looked after by nurses. At the end of the day, like I said, those patients on the ramp are being cared for by a skilled health professional one to one by a paramedic. Presumably if they are Cat 1/Cat 2, they straight to Resuc, but if that patient deteriorates, they have a paramedic there to support them and, presumably, they've been moved into the emergency department quicker in that situation.

The difficulty is that the environment - like James said the room around the back, at the Launceston General Hospital, it's an airlock - is not an appropriate place to be providing safe patient care. As it is, we have an overcrowded, overcapacity emergency department where, even with, for instance, at the LGH with the 21.3 full-time equivalent nurses, we hear consistently from nurses in that emergency department that they don't feel that it's safe. It is

not safe for them to then be expected to care, even with additional staff, for patients who have been brought in by ambulance.

Presumably, if they're well enough, they'd be diverted to GPs and waiting rooms. These are really sick people who need appropriate bed spaces, an appropriate triage category and an appropriate area rather than saying, 'Well, we're just going to offload you into the airlock or the room around the back, even though you might be a Category 2 patient who needs oversight and appropriate care in an appropriate environment where you can be carefully monitored, seen and care can be escalated in a timely way if you deteriorate prior to diagnosis'.

Mr LLOYD - We also have to realise that patients who come to the ED don't just come in ambulances. They walk through the door and go to the waiting room so you have the nurse navigators who do the overall coordination in the ED. If they have a cubicle which is free, they have to decide, 'Do I get that patient off the ramp or do I attend to the patient who has chest pain waiting in the waiting room?'. Often, people say 'ramp' because the sicker patient in the waiting room has to go that one cubicle. It is all about capacity.

CHAIR - You have talked in your submission:

> The primary cause is the bottleneck within hospitals due to limited capacity and inefficient flow of patients.

Can you talk about the role of what nurses would like to see to have more efficiencies in the flow of patients? Is there anything about staffing ratios? Is there evidence of understaffing at different parts of the hospital that could help reduce the bottlenecks and flow issues?

Ms SHEPHERD - As I mentioned, some of those system issues would really assist. In terms of the 24/7 radiology pathology, also pharmacy as well. Patients might be fine for discharge but then they are waiting for hours to get their discharge medication and that patient presumably could have been - yes, some might go to transit lounge but then presumably that patient was fine for discharge but then waiting for hours. So, additional pharmacy technicians to be able to support the provision of timely discharge medications.

In terms of patient flow, part of the issue in relation to staffing is that a lot of our wards and units - 2016 we had assistant nurse unit managers implemented under nursing [inaudible] per patient day. At the time our view was that those roles needed to be indirect or backfilled so that that person could be without a patient load. We know across the state there are still some areas where those roles are actually carrying a patient load, as James alluded to, in the emergency department as nurse navigators.

Effectively, those roles - and that's only at the Royal Hobart Hospital, the nurse navigators in ED, there aren't any nurse navigators at the LGH or North West Regional or Mersey - they're the types of people who are really focused on access and flow and moving patients in and discharging patients out; identifying those patients who might have complex needs on discharge, sending early referrals, ensuring there are multi-disciplinary meetings occurring to ensure that care pathway can actually be streamlined.

Some of those roles are still carrying a patient load while also trying to coordinate the flow of patients into and out of wards. Working with the bed managers and that is a really critical role, we feel, in terms of access and flow. We also think that there could be a broader

role in terms of nurse navigators not just in the emergency department but to try and facilitate the appropriate transfer of care of patients, working with patients and families around discharge destination at time of admission or presentation to the emergency department -

CHAIR - A nurse navigator to do that, is that what you are saying? Or would that not be occurring by nurses in the wards, the general medical ward, wouldn't that be where that was happening? Or are you advocating to have a specific discharge nurse? Is that what you are proposing?

Ms SHEPHERD - A specific role, yes. I think part of the issue is that the medical team, or surgical team or whatever specialty it might be, will be responsible for diagnosis and estimating the date of discharge. The nursing staff then obviously are providing care to the patient in the admittable ward or unit but also too then responsible for discharge planning. Often those conversations around discharge planning don't occur until the patient is on the ward or unit. If we can facilitate somebody with a broader lens to look at discharge planning from admission to actually oversight that process in terms of -

CHAIR - That was proposed by a nurse who gave evidence to us that that should happen right at emergency. The expected date of discharge or the likely date of discharge should start at that point so that the family could be brought in early on and have some sort of sense of that time frame. Can you explain what is stopping that happening now? Is it just a protocol or not enough staff?

Ms SHEPHERD - The estimated date of discharge?

CHAIR - Yes, starting that conversation in ED, why doesn't that happen now?

Ms SHEPHERD - Because often, one, there are the issues - around which we have already talked about in the emergency department, that the person might be waiting for a bed for days in the emergency department - so it is not the role of the emergency department nurses to start discharge planning discussions. They are there to provide emergency care. Then by the time they get to the ward, that patient who has been in the emergency department for two days could be further deconditioned. That pushes out the expected date of discharge. Then, of course, the situation has changed. Then the treating team has to review the patient.

The whole entire length of stay could be pushed out and the requirements might have changed and then they have to reassess - is it that he deconditioned in the emergency department or is this a new symptom or sign that we have to take into context. I think all of those delays contribute to the - we can look at the average length of stay from a national perspective and from a funding perspective. But that's in an ideal world where we don't have the challenges around access and flow.

CHAIR - I hear what you are saying about the fact that there many other variables that can intervene. What we have heard previously is that, as James has said, a lot of people who are coming are coming in older. There is an increasing proportion of people who are coming who may not be going home and may not be able to be cared for in their current place of home. Regardless of whether they are in hospital for three days or five days or seven days, that is probably likely to get picked up early on. The earlier that there is a capacity to start coming in with arrangements for the end that was proposed, that would help with efficiency. Do you

think there would be value in having a specific person, not loading it onto nurses, but a specific role for a discharge person at the beginning, in the ED, as well as at the end?

Ms SHEPHERD. Yes. That's the nurse navigator role. Perhaps not in the emergency department but a discharge coordinator-type role that would actually work with those patients coming into the emergency department who are flagged as complex needs who were likely to have discharge challenges. Often that can be fairly evident upon discharge. It might be a patient who has come in with multiple falls and has had multiple admissions over a short period of time. There might have been previous conversations in previous admissions: 'After a period of rehab, if things don't go well at home, we might need to have a discussion around supported care or residential aged care'.

Sometimes some of that foundational work has already occurred but then they present again. So, I think having those conversations early are absolutely helpful in terms of facilitating a timely discharge, albeit some of the challenges around not just those aged-care placements but also those with NDIS. Also recognising the numbers of patients who are transferred from residential aged-care facilities into emergency departments as well. I think there are multiple factors that contribute, that those patients potentially could be cared for in another setting rather than in an emergency department.

Ms DOW - I wanted to clarify with the nurse navigator positions that there currently is just one position across the state, at the Royal. Is that right?

Mr LLOYD - At the Royal, yes. They are in the ED. It is just not one position. It is every shift, bar night duty: in the morning and afternoon shift they have two nurse navigators in the ED and on night duty they have one. It is multiple positions. It is probably 16 people who cover the whole roster, for example.

Ms DOW - Thank you. My second question flows on nicely from what Emily was speaking about before. In your submission you talk about further actions for the state Government and the expansion of the Community Rapid Response Service into aged-care facilities to prevent ED transfers to begin with. Can you expand on that a bit for the committee, please?

Ms SHEPHERD - Yes, sure. I think that is another key point and position of the ANMF: that there are patients who present to the emergency department who could be receiving care at home or in the community, or, obviously, for those from residential aged-care facilities, in-facility.

The Community Rapid Response team has been absolutely instrumental in supporting the prevention of emergency department presentations in the community. They can be referred through to that service from direct referral from general practitioners and from those facilities as well. I think that provision of care that is nurse practitioner-led as well can provide that acute supportive approach to those patients who might need that increased care but not necessarily as an emergency in an emergency department. Those types of services and teams have been absolutely critical in preventing admissions.

Looking at other services, palliative care, for instance, we know is only funded, again, to business hours. Often we hear from members in the emergency department that they have presentations of palliative care patients, particularly in the terminal phase where there might

be pain issues, or there are other types of concerns that have come up that they can't deal with over the phone, and they have no other alternative but to present to the emergency department. Having a 24/7 palliative care funded service would obviously assist in that regard.

Thinking more broadly as well in terms of community services, we've got our community nurses functioning in the community. We know from Community Rapid Response, having that referral and the oversight by nurse practitioners could be an added benefit to the community nursing teams; to have those nurse practitioners within the community nursing teams for that escalation to try to prevent those patients who might then bounce back post-discharge, or even in community receiving ongoing community care.

Other services like the community dementia teams, who are instrumental in supporting those patients living with dementia, where they can go in to provide that additional top-up to federally funded packages. But being able to be more flexible, so that they can just go in for 10 or 15 minutes and assist with medication administration so that there's not the issues around polypharmacy or critical medications being missed. Then you're not having syncope or people having falls or fractured hips as a result.

I think exploration of those existing services and how they can be expanded is probably also quite a cost-effective measure in terms of trying to look at supporting the reduction in inappropriate emergency department admission.

CHAIR - Thanks, Emily. James, as a nurse manager, would you like to share with us about staff experiences of the impacts of ramping and transfer-of-care delays? How does it impact on nurses?

Mr LLOYD - When it comes to ramping and overcoating in ED, essentially, we're all asked to work harder, which we do.

CHAIR - You already work pretty hard anyway, don't you?

Mr LLOYD - Yes, we work hard anyway, and we're asked to work harder and harder still. People are already working at 100 per cent, so they start getting stress and they start getting worn-out. When people start getting tired and worn-out, mistakes start happening down in ED, which is really stressful. Sometimes you'll get patients who will suddenly take a downturn for no one's fault and for no interesting reason, and that can really impact on the staff as well.

The whole ramping issue and the overcrowding at the front door of the hospital has a massive impact on the staff in ED and also the staff on the wards. You have these people wanting to get into beds and we want to get them into beds, but we can't get them into beds because we don't have the capacity to get them into beds, or we don't have the staff. That really impacts on nurses who are sitting there seeing the ramping going on, seeing the crowding going on downstairs. It can be very stressful. I know in our Royal Hobart Hospital ED there has been a massive turnover of staff because of that over recent years.

CHAIR - We've spoken to some of the people who've left.

Mr LLOYD - Unfortunately, a lot of them are experienced staff. They get out and go to other jobs and other positions, which means the overall experience level in ED goes down.

This means you don't have the right type of nurses, say, like resuscitation nurses to take care of patients in Resus. Therefore, more junior people have to step up and that's quite stressful for them to do that. It's a compounding, snowballing-type of thing that goes on down in the ED and it does get onto the wards as well.

One of the other things I wanted to say about the wards is the point when you come to bed blocks and not have enough capacity is, as bed managers, we end up having to put patients in the ED a long time into wards that are not their home wards. For example, I've got an oncology patient who has been in the ED for 18 hours, I really need to get this patient out into a bed because they're 80, they need a proper bed, so I end up not putting them on the Oncology Ward because they're full and there is no one to move out of there, so I put them onto a secondary ward that is not their home ward.

CHAIR - Just a general ward or something.

Mr LLOYD - Yes, like a general ward, you know, the nurses there are really good, but they don't have the experience in oncology, therefore the patient's length of stay is longer, the oncology doctors have to go searching for their patients in the hospital, which means they're not getting timely care. That causes a lot of stress on the system as well.

CHAIR - Would they get moved into the proper ward when a bed comes up?

Mr LLOYD - Yes, eventually, but then you're causing more chaos in the system and more work in the system, because as a Patient Flow Manager, my philosophy is to get the right patient into the right bed first time and because we don't have enough capacity, we can't do that. The right cases in the right beds so we have to put them into sub optimum beds.

CHAIR - We've heard from another person who said that in their view, at times wards that have empty beds because there is not enough nursing staff to fill them.

Mr LLOYD - Yes.

CHAIR - Does that ever happen, where beds don't have people in them.

Ms SHEPHERD - I'd probably say that is true. What I would say more often than not occurs is that those beds are filled without sufficient staffing. So, it contributes to the burnout and it contributes to the exhaustion and the moral injury that our members have experienced for quite a long period of time, particularly exacerbated from COVID-19 with significant vacancies and people choosing to leave the profession and bringing forward retirement. That option, more often than not, we know that wards and units are working to the benchmark to require the minimum in terms of staffing because of those vacancy rates.

Often, if we push and take matters to the Industrial Commission, we will get agreement to close beds for a period of time until vacancies are filled and sometimes that is done by the THS of their own volition in situations where clearly there's such significant vacancies that staffing can't support that bed capacity.

CHAIR - Would you say it's just that the wards are theoretically staffed to the level of staff that's needed for the beds, but because people leave and then recruitment doesn't happen or retention isn't happening, then nurses aren't available to fill shifts because they are working

at unsafe levels, then the beds wards are closed or nurses effectively stand down from working in those wards until they are properly staffed? How would you describe it?

Ms SHEPHERD - I know they have to ask to complete multiple double shifts and overtime to try and keep staffing those wards and units and, obviously, that's part of James's role, is finding staff to do double shifts to staff beds effectively.

CHAIR - You've been talking about this for years now, haven't you? I remember we went to the access bed block round table, big event that Michael Ferguson organised when he was minister and this was all going to change. Do you want to tell the Committee what's happened in terms of getting the staffing increases that are needed, that were recognised at that point?

Ms SHEPHERD - I think the staffing situation is worse than it was at that time, which I think was around 2017/2018. Obviously, we foreshadowed at that time that the research from 2014 that indicated we've got an ageing population and ageing workforce where we're going to see significant losses of nurses and midwives across the country and internationally. We foreshadowed that in 2018, unfortunately that meant that we then encountered COVID-19 in 2020 which exacerbated the shortfall in nurses and midwives, and unfortunately, we're now seeing multiple vacancies. As James alluded to before, we're now very much reliant on our graduate nurses coming through as our pipeline of more nurses, potentially more midwives as well, but they need additional supports.

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

CHAIR - What is the hold up? Why isn't it happening?

Ms SHEPHERD - They are not funded.

CHAIR - There has been a recruitment round table or something like that that ANMF was part of after the last election.

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

CHAIR - It just hasn't appeared in the budget?

Ms SHEPHERD - No. They weren't funded positions and now the individual regions and hospitals are saying that they don't have budgets to be able to implement those positions. The work required to actually do the analysis around the wards and units where 30 per cent or greater of the staffing establishment being made up of graduate nurses, enrolled nurses or those transitioning form other sectors, for instance, aged care to the acute sector, has only been done

at one hospital rather than all hospitals to identify which wards and units need those clinical coaches.

Ms O'BYRNE - I think you've probably picked up on most of what I was going to ask. What data do you keep on two issues: 1) The amount of times that wards are inappropriately staffed and I accept that people do the second shift and the third shift in a week in that timeframe. What data do you keep on that?

Ms SHEPHERD - Unfortunately, one of the commitments from the Premier in July last year was to establish a nursing dashboard to try and capture that data, because one of the issues that we encountered was when we consistently raised that wards and units are working below their benchmarked hours, we're told that they don't capture that data of when wards and units work short. We occasionally capture -

CHAIR - Can I just clarify for the committee, when you say work-short do you mean -

Ms SHEPHERD - Below the benchmark minimums.

CHAIR - The beds aren't filled, or that there aren't enough bed staff to the benchmark?

Ms O'BYRNE - Under an HPPD, is that what you mean?

Ms SHEPHERD - Yes, that's right.

CHAIR - For people who are listening what is that?

Ms SHEPHERD - Nursing hours per patient day, which is the workload model which dictates the minimum staffing requirements per beds and patients. But when we say below the benchmark minimum we say that is below the minimum staffing requirements and that is usually irrespective of whether the beds are usually filled in those scenarios where we might be raising a grievance in relation to workloads for those areas, which means that they are being staffed through staff picking up overtime of completing double shifts.

CHAIR - Sorry, I interrupted you, you were talking about the nursing dashboard but that hasn't happened?

Ms SHEPHERD - The nursing dashboard isn't yet live. There has been a fairly significant amount of work occur in that space, but it isn't yet live. In terms of data, I think your question was around what do we retain? We only ask our members to report to us if they've raised a workload grievance, we'll ask them to undertake a period of data collection in relation to a specific workload query so that we can substantiate the issues and be able to then take that to the THS to say, 'Well, this is obviously what is happening'. Of course, that's another requirement on our members to do that and some members choose not to do that because they are exhausted and they don't want to have to be completing more paperwork at the ends of their shifts. I couldn't say that our data is completely accurate. It is usually just a bit of a guide in terms of what is actually occurring in terms of workloads.

Ms O'BYRNE - My second question, through you, Chair. Exit interviews when people are leaving - because we do hear of people leaving because they're exhausted and stressed - are

the department conducting exit interviews on that or do you have feedback or information on that that you can provide to the committee?

Ms SHEPHERD - Sure. As James alluded to before, we know that, particularly in our emergency departments, and I'll use the LGH as an example - when we ran our *Bring Your Own Bed* campaign, one of the strategies we put up to resolve part of that grievance and to try to retain very experienced and senior emergency department nurses was to actually conduct exit interviews with those who were leaving and to share those responses.

More often than not, the exit interviews didn't occur, and where they did, they only occurred during the period that the grievance was live or obviously the information was shared with us. But those members of ours who had left the emergency department and transferred into other roles often would not have had an exit interview. Often that's because they're transferring to another role within the department or within the Tasmanian Health Service. A couple, for instance, moved from the emergency department to work as school nurses under - as it was then - the Department of Education, so they were seen as a transfer as opposed to a staff member leaving the emergency department because they'd quite frankly had enough.

Ms O'BYRNE - Thank you. I did have one other question, but I might come back to it. It may be something I can see from the report.

CHAIR - I wanted to clarify, James and Emily, from what we were saying before - one paramedic made the comment in their submission that there are plenty of beds in the hospital, there are just no nurses to look after them. Bed space is rarely an issue. I can see you're shaking your head. What's your response to that?

Mr LLOYD - It's two factors. It's definitely staffing, so we don't have enough nurses, but we don't have enough physical capacity. Sometimes, if you were to look at the stats of how many beds in the hospital, you'd probably see all these beds that are not being used, but a lot of those beds are maternity beds, so obviously you're just going to have pregnant mothers and babies in the beds. You're not going to put a guy who's got a chest infection into that bed, for example. There's also paeds beds, and often paeds one day will be completely chockers and the next day they'll be at half their capacity. But you can't really use those beds for adult patients.

CHAIR - Where do you get the information about what beds are free? Is that available to you as a nurse? Can we get it?

Mr LLOYD - Yes, to anyone.

CHAIR - How is that available to anyone? Can the committee get access to that?

Mr LLOYD - We use various software systems in the hospital to track beds and ensure capacity. There's one thing called Kyra, or patient flow manager -

CHAIR - Yes, we did go through Launceston.

Mr LLOYD - There is a screen there that shows me and can show anyone who has access and a login to the THS. It's exactly all the wards, what their funded beds are, what their open beds are and how many beds are unfilled at the moment. There's a huge thing that says -

CHAIR - It's global beds, not by ward? It's not by general medical or by surgical or oncology?

Mr LLOYD - No, it's a global thing.

CHAIR - It's the whole thing; it's the whole number. So what you're saying is that people can misinterpret that as thinking there should be lots of surgical or medical beds?

Mr LLOYD - For example, if you got the surgical short-stay unit, which is really only a nine-to-five - the hours are a bit longer, but they're really not overnight beds - sometimes those beds are captured up and people think there's all these beds here, but actually, they're only really day beds. You've got the medical day beds in ACC, which are only used during the daytime between eight and ten in the evening. You might even have ICU beds that are not being used because the right type of patient is not in that bed. When you look at the numbers, it actually looks like we've got dozens and dozens and dozens of empty beds, but they're the wrong types of beds.

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

CHAIR - Cleaning staff, in that instance.

Ms SHEPHERD - Yes, exactly.

CHAIR - Do the cleaning staff work overnight?

Ms SHEPHERD - There's a lack of - how do you call it - shared roles across multiple wards and units, but certainly even just after hours. One of the issues we raised during COVID-19 - you could imagine with the increased infection prevention and control measures - with the Health and Community Services Union. We called for additional funding to support the ongoing support roles, which included those ward clerks, ward aides and cleaners to be able to support and facilitate the appropriate infection control procedures, but also to aid in access and flow, particularly just in terms of answering the phone after hours - the phone is ringing off the hook, and people not being able to communicate because of locked wards and units and not having the appropriate numbers of support staff.

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

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

CHAIR - We've got to wrap up now. Did you have one other, Michelle?

Ms O'BYRNE - I wanted to ask in that same sort of question flow - patients sometimes are referred for a ward bed, but even though the bed may be open and there may be staff, the mix of skills for the staff, if they happen to have quite a few students or graduate placements, mean that they aren't necessarily taking them. The conversations you often have with staff are like, 'We could take somebody but we probably have too many highly dependent patients right now to take on another clinically at-risk one'. Would that be something you would see a lot of?

The other question relates to the amount of times people aren't transitioned - once they've made it through the ED, they're then blocked somewhere else. They may spend quite some time in an ICU bed, which is highly expensive, waiting for a ward bed to become available. Could you just touch on those two points?

Ms SHEPHERD - I'll start with the second point - Kylie might talk about that from a theatre perspective, if that's okay?

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

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

Ms SHEPHERD - The first question, Michelle, just in relation to skill mix - I suppose just what you described in terms of not being able to accept those patients with high acuity needs. That absolutely factors into it, then often that's probably pushed back to the bed managers to say, 'Look, we just haven't got the skill mix; we've got some really acute patients at present. Is there another bed available?'

Often too, examples of where patients might be physically aggressive and violent. There are times where those patients might be in wards and units, and multiple staff have been assaulted. There's a lot of trauma. Those wards might push back and suggest that perhaps another environment or another ward might be appropriate. There are times where skill mix and also the patient type might potentially mean that there's further consideration about whether it's appropriate to move that patient into that bed. I don't know if you want to add anything to that, James?

Mr LLOYD - That scenario that you presented does happen on a regular basis, where essentially we have a ward where we've got a patient in ED and it's their patient, and they don't have enough experienced staff to take care of that patient. Often it's because of sick leave, because the experience often was stressful, whoever was running the ward is on sick leave because they have gotten sick and we have no experienced staff to send there. We have to try to figure it out, usually by over-staffing that ward, by giving them extra resources, which we

have to take away from another area to put into there so we can allow that patient to go there. It can be very tricky. We have not talked about sick leave. Sick leave in a hospital is probably one of the big issues that we have, because we usually have no-one to replace. We do have a casual pool and a permanent casual pool but that is not enough to replace the high amount of sick leave that we get.

CHAIR - So, it would be fair to say that although the ANMF has been calling for some, like, direct actions through the recruitment round table or whatever that mechanism is called, that they have not been funded yet in the budget to be able to increase the size of the pool? Has there been an increase to the size of the nursing pool in the last 18 months, two years?

Mr LLOYD - One thing I will say is we cannot get staff to do it, to join the pool and join the permanent pool and that is one of the biggest - we cannot get the staff to join it because they are all going off to Queensland -

CHAIR - Wages and conditions?

Mr LLOYD - Wages and conditions and bonuses to go to Queensland and just stuff like that, we cannot. You know, if you are young and you are free and you do not have any mortgages or anything like that, you want to go to Queensland and have some fun and, you know, they are going to offer you a cash bonus to go there and they will give you accommodation for a certain period of time and so forth. We need to hold our staff and our young here.

CHAIR - Yes. We could keep talking but I am afraid we have to wrap up now and thank you so much for your submission and everything you have told us today. I remind you before we leave that everything you have said here today is protected under parliamentary privilege but when you walk out the door if you have said anything that might be a matter of legal action or defamation, you are not any longer covered. You all understand that?

Ms Shepherd, Mr Lloyd and Ms Stubbs - Yes.

CHAIR - Yes. I thought so. Thanks so much for coming into today. I really appreciate that. We can stop the broadcast now. We might just have a two-minute break and then we will bring the next people in.

THE WITNESSES WITHDREW.

Committee resumed 1.36 p.m.

Mr LUCAS DIGNEY, ASSISTANT STATE SECRETARY, HEALTH AND COMMUNITY SERVICES UNION, (HACSU), AND **Ms SIMONE HAIGH**, CLINICAL SUPPORT SUPERVISOR, INTEGRATED CARE, AMBULANCE TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Before we begin, did you receive the guide from the secretary of the committee explaining parliamentary privilege.

Both WITNESSES - Yes.

CHAIR - This committee is a proceeding of parliament and our job is to inquire into ambulance ramping, transfer-of-care delay and so that we can do our work really well, you have parliamentary privilege so that you can be free without fear of being sued or questioned in court or another place. You need to be aware that the protection you get from parliamentary privilege doesn't follow you when you leave here and even if you say the same things that you said in the room here, if you say them outside, you don't get the cover of parliamentary privilege. Today there might be people from the media and there will be members of public watching online and if there is anything that you wanted to say in camera, then just let me know and we can turn off the broadcast if that was needed.

Do you understand that?

Both WITNESSES - Yes.

CHAIR - I want to start by thanking the Health and Community Services Union (HACSU) for the excellent submission you provided us and the wealth of paramedics' personal experiences. It's really valuable for the committee. We wanted especially to hear the voices of people who were working on the frontline - paramedics, and, obviously, patients. We appreciate that. I want to start by talking about the recent staff survey that you have undertaken. I understand that 67 per cent of HACSU ambulance members said that they'd consider leaving Ambulance Tasmania because of ramping. Do you think that sentiment is reflected in the real changes that we're seeing in the workforce? Are people leaving? Are they reducing their work hours?

Mr DIGNEY - Yes, they are, Chair. Increasingly our members are seeking part-time work arrangements or considering work outside that of an operational paramedic because of the pressures caused by ambulance ramping. We see week after week members of our ours who are employed as full-time equivalent paramedics seeking a reduction in their work hours and that is mainly due to the workload that's caused by ambulance ramping.

CHAIR - We've certainly heard from members who have left - long-serving paramedics who have left because they're burnt out and they've described the experience that has changed on the ramp over the last several years since 2016-17 but especially in the last couple of years and the rapid increase in pressures for them with spending more and more time on the ramp.

What are you hearing from members about the changing conditions on the ramp and how it's affecting people's mental health? I've read some of the comments in the report.

Ms HAIGH - It's quite devasting, really. You have to take into consideration the whole approach to this because already the job is potentially damaging for mental health. Then, on top of that, to be stuck in a hospital with a patient. Particularly in the last couple of years, as you've pointed out, it's increasingly worse and higher acuity patients being ramped. It's not unusual for what is classified as a Category 2 patient, who is quite unwell, to be ramped. That adds extra stress to paramedics all the time. It's not a one-off event that this is happening; this is happening nearly every day that they are stuck with these sick patients.

Not only are they in these stressful situations with these sick patients, where at times, as we know, some people have died on ramps because their illness has progressed suddenly, but also we need to remember the people out there in the public, so there's a moral injury that also goes with this.

All paramedics are expected to carry a portable radio on them. They can hear what is going on out in the rest of the community and they can hear: P1, which is an emergency case, Glenorchy, no response; P1 Launceston, no response. That is an emergency case. What a lot of people forget is that the patients who are on the ramp are actually in a hospital but the patients who are out there in the community have no one there to look after them when they are suffering their medical emergency. It's really difficult for paramedics to not only be stuck on the ramp with patients that they can't get the best care for because paramedics are obviously limited with what they can do. They are also hearing all these other cases going off where there is no response and no support for these patients.

The reason why we are here is to look after the people of the community and we are unable to do that. That causes great distress and moral injury to them.

Mr DIGNEY - At its heart, Chair, an ambulance service's core function hasn't changed for hundreds of years. They were first designed to sally onto the battlefield, collect injured soldiers and take them to a field hospital. In our context, they're charged with going out into the community, into uncontrolled environments, managing and stabilising people who are in a medical emergency and then transporting them to a tertiary health facility, in our case hospitals.

It is soul-destroying to them that they get Category 2 patients, as Simone has mentioned, to a hospital and then there's no further intervention available for some hours for that patient and their condition just worsens over the time they are ramped with the paramedics.

CHAIR - In your staff survey, 80 per cent of members said they felt they had ignored policy or compromised normal operations because of ramping. Can you give us some common examples of the sort of things that people might feel forced into doing?

Mr DIGNEY - The main example that we picked up out of that survey was that it's about interventions that are being initiated by other health professionals - doctors, clinical nurses, that are not within the scope of paramedics' practice, so they're not allowed to do those interventions themselves. But because of the worsening nature of the patient or the fact that the paramedic just wants the best outcome for the patient, they often ignore the protocol that's in place that says shared care is not a thing we can enter into.

If you want to start an intervention, if you want to start a syringe pump or some other intervention that's outside my scope of practice as an individual paramedic, then you're obligated to take the patient as your patient. Increasingly what we see, because of the

circumstances that Simone described before, paramedics are ignoring that protocol for the good of the patient. They are also placing themselves at some great risk by doing that because if something goes wrong, it's unclear whose professional or clinical responsibility that particular decision flows back to.

CHAIR - I suppose they can't just say, 'Well, over to you, I'm walking away', because they might be on an ambulance stretcher at that point. So they can't actually just say, well there you go.

Mr DIGNEY - Quite often there is no contemplation of admitting the patient or taking handover of the patient. The other health professional knows that that intervention is probably best to start sooner rather than later and, in the circumstances, there is nowhere to admit the patient, there is no one to hand the patient over to. Again, not trying to besmirch the individual health professionals involved in those decisions - they are trying to do the best thing by the patient in the circumstances, but if there is an adverse outcome or an adverse event for that patient, then it is our members, it is the paramedic who is wearing the risk.

CHAIR - That might be why, in your staff survey, 93 per cent of ambulance members said that they felt unsafe personally or professionally on the ramp. That is almost everybody on the ramp feeling unsafe. Can you tell the committee what the main reasons for that are? I think you alluded to some just then.

Mr DIGNEY - All of the reasons from my previous answer, Chair. But there is pressure put on paramedics, too, because they are allowed to hand over their patients to another paramedic. For example, if I had a patient on the ramp and Simone arrived with a patient but they are trying to clear a crew because there is no response available because all of the crews are ramped, Simone or the operational supervisors who are charged with trying to manage this dreadful situation might make a decision that I've got a category 3 patient, Simone has also arrived with a category 3 patient. I will take that category 3 patient and have two patients so the other crew can be cleared to respond to the community.

We also see conflict between emergency staff and paramedics about acuity, about who should be admitted first, about whether this patient is suitable to be left in the waiting room or any of those other decisions. Increasingly, our members feel unsafe because patients' conditions worsen and there is seemingly no solution, no expedited admission for that patient because they have to triage everybody who is essentially at the front door of the emergency department. There are certainly decisions made that say: well, this patient and that patient are maybe equal in acuity but that patient has walked in and that other patient is with a paramedic, so we will leave that patient with the paramedic and we will prefer that one that has not had any intervention.

CHAIR - Have you had any examples of ambulance members being on the ramp, exceeding the scope of practice or protocol for exactly the situations you have described and then suffering consequences, suffering some kind of professional sanctions from Ambulance Tasmania? Or are these things generally just sort of overlooked because of the situation that we are now in?

Mr DIGNEY - We have certainly had members questioned about what decision-making was involved in that particular intervention or that particular case, but I do not have any examples of anybody being sanctioned, for example, by the regulatory authority.

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

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

Ms HAIGH - Just to add to that, all the decreasing in the work hours, sick leave and workers comp for mental health, there is no sort of fat in the system to cover those people on-road. So, not only are they getting exhausted from all the ramping and just constant work without a break; they are also running crews down and that is happening statewide.

CHAIR - Running crews down in terms of people not turning up to shifts?

Ms HAIGH - Yes that, and they're just unable to fill the shifts or we don't have enough staff. We really don't have enough staff statewide to cover any unplanned absences, let alone people getting their adequate leave and things like that. So, this all has a knock-on effect to then you have less crews available, they're ramped and then all of that more exhaustion, more stress, more inabilities to respond, more injury and psychological distress. It all has a knock-on effect and it just compounds itself.

Mr DIGNEY - We've seen as recently as Saturday night, for example, Chair, the northern regions, so, Ambulance Tasmania is staffed by region, north-west region, northern region and southern region. Just on Saturday night, for night shift, the northern region muster was 40 per cent covered. So, 40 per cent of the available ambulance resources that would normally be rostered for a Saturday night, which is a busy night in terms of the week, at the commencement of that shift there was 40 per cent of those shifts filled. In the north-west -

CHAIR - So, 60 per cent not filled.

Mr DIGNEY - Yes, 60 per cent not filled, Chair. In the north-west we see crewing of 50 per cent, 60 per cent, 70 per cent, on a daily basis.

CHAIR - How old is the staff survey that you did? How long ago was that?

Mr DIGNEY - When were submissions due, Chair. It was done around the time of the submission.

CHAIR - October, November.

Mr DIGNEY - In the second half of this year.

CHAIR - I'm hearing a real desperation in your voices and the evidence of the survey, the evidence of the rapid decline in people being able to take up shifts because they are just so

exhausted and burnt out is really concerning. Do you think this is at a point of potentially getting rapidly much worse than it currently is?

Ms HAIGH - Yes, basically. I think we're at a crisis point at the moment because it is progressive. It is starting to rapidly get worse. I've been a paramedic for 18 years and this is the worst coverage I have ever seen in that 18-year period. At Estimates earlier this year the government handed that down ORH (Operational Research in Health) report, which was six months ago.

CHAIR - The ORH report, for people who are listening, what does that mean?

Mr DIGNEY - It's an operational report into Health.

Ms HAIGH - That was handed down with recommendations for 126 paramedics, which is a minimum amount of paramedics really that we need to cover what is going on. That was six months ago and we have seen no action on that. Not only did that report pick up that we need more staff, that this has all been compounded on top of it. Then there is the ramping increasing and the staff coverage decreasing and it is coming to a crisis point.

Mr DIGNEY - The Government had, earlier in the year, made permanent 90-odd, 97 paramedic positions that were COVID-19-funded -

CHAIR - They are not new positions?

Mr DIGNEY - Absolutely not new positions.

CHAIR - They were casual and now they are permanent so there is no extra staff that came through that.

Mr DIGNEY - Not one.

CHAIR - You've been advocating to the Government for action on ambulance ramping for a very, very long time. How do you characterise this Government's response then to what you have been asking for?

Ms HAIGH - Poor.

Mr DIGNEY - They haven't really come up with any tangible plan, Chair. Ultimately there has been a number of different health ministers over the period of this Government's life but ultimately, none of them has brought any additional resources to bear in ambulance in real terms. In fact, if you look at the ORH report for 2010, the ORH report from 2014 and the ORH report from 2022, very few of the recommendations in a report that was commissioned by the state government at the time have been implemented. Over that time, we and other interested parties have made it clear to both the Department of Health and the Government that if they don't increase ambulance resources, we are going to end up in a mess.

We probably couldn't envisage the mess that we're actually in today but they've been told time and time again over a number of years. We'll table some correspondence later, Chair, for the committee to review that goes back to 2017 - both to the Department of Health and to executive ambulance management - about the need for more resources and specific resources.

We have made it clear to them what they can do, both in the short term and the longer term to alleviate some of the pressure. Whether that solves ambulance ramping is unclear, but what it would do is it would take the incredible burden that sits on the workforce at the moment away because there would be enough ambulance resources to at least meet the current demand.

Ms HAIGH - To add to that, with the Operational Research in Health (ORH) report it only talks about paramedic resources; it doesn't discuss all the support resources that need to go around hiring those extra paramedics. For example, we got the extra 97 during COVID-19 so we don't have the educators to support them; we don't have the administration, the managers. The coronial inquest into Damian Crump's suicide showed that we don't have the management that's suitable to look after the volume of staff that we have. Some managers are looking after 200 staff and that is not appropriate.

So, the investment needs to not only just be in frontline staff but all that support staff around them to make sure that they can do their job safely and effectively.

CHAIR - An immediate, critical investment in resources. You have been asking this, I think to be clear, from 2016-2017 when it started occurring?

Mr DIGNEY - Yes, absolutely.

CHAIR - From what you're saying, it sounds like the Government has not been listening to you. You have been making very clear statements and warnings about what you could see coming that's here now. How does it make you feel, having repeatedly warned the Government for years and years to see the situation become as bad as it is at the moment?

Ms HAIGH - Incredibly frustrated. We feel let down, to be honest, because we're trying to do what's best for the people of Tasmania and no-one seems to be listening to us. That in itself makes us feel isolated and that we are just not being heard. Ultimately, there are going to be bad outcomes if we do not resource the ambulance service properly so that we can look after the people of Tasmania. They are our employers. The people out there employ us to look after them in their time of medical emergency and we are really frustrated.

Mr DIGNEY - It also makes us increasingly motivated to do something about it, Chair, and what I mean by that is - our members are increasingly exasperated and they are increasingly more inclined to take industrial action to try to force the Government into providing the resources that they've so long asked for.

CHAIR - That's a huge step to consider.

Michelle, I have a few questions to finish this line and then I'll come to you.

Over the past few years, the Government's commissioned a number of reports and you've mentioned the ORH ones into ambulance services and resources. Have you seen the Government's reports and, if so, what's your understanding of the key common findings and recommendations?

Mr DIGNEY - All of the findings basically say you need more resources. You need more paramedics. As Simone has quite rightly pointed out, that's only on the face of it. If you get more paramedics, you've also got to have more communications staff. The staffing issues

that we talk about don't just face our on-road paramedics. Quite often, the state communications centre is understaffed. So, we've had examples this year of the state communications centre not having any call-takers. Essentially, duties are split in the state operation centre between taking calls and dispatching ambulances and other ambulance resources and, increasingly, what we see is those roles are having to be combined because of inadequate staffing.

CHAIR - I'm not sure if you heard the testimony on Monday provided by two paramedics, Ryan Posselt and Cameron Johnson, about a response that the Department of Health provided to this committee.

We asked about the number of patients who have died whilst on the ramp in the past five years. The department says the answer is none; they've recorded no people have died because care is transferred when patients deteriorate to that point.

Mr Posselt described that as being a 'lie' and Mr Johnson described it as 'slippery' and 'weasel words'. What do you make of those comments and the department's response?

Mr DIGNEY - It's simply untrue, Chair. There have been patients who have died while they have been in the care of our members on the ramp at the Royal Hobart Hospital. It's that simple. I believe that the coroner is investigating either one or a number of those deaths. What is one of the issues for the department is the way that they record data. For example, the system that paramedics use to record patient information and data is not the same system that the staff in the ED use. Those two systems don't talk to one another, so - in the interest of giving the greatest benefit of the doubt - there may well be some holes in the data that's collected by the government. But ultimately, to say that in that period no patient has died while they've been ramped in an ambulance is quite simply untrue.

CHAIR - Okay, thank you. Michelle?

Ms O'BYRNE - I only have three questions and I'm sure you will be able to deal with them reasonably well. The question about deterioration on the ramp - when we attempted individually as members to get an idea of how often people's condition deteriorates on the ramp, the department says it doesn't really collect that data because it's such a moving feast. Does Ambulance Tasmania collect that data? Would you have a tracking record of patients in your care who have significantly deteriorated in their classification, or is that only held by the ED?

Ms HAIGH - By rights people should be doing a SRLS about that, so a Safety Reporting Learning System. One would think that we are tracking that data. I personally am not privy to that, but yes, it would be tracked.

Ms O'BYRNE - So it would be on an SRLS. If that's what we asked the question about, do you think that's how we would find that information?

Ms HAIGH - If the crews have done their due diligence and done an SRLS, yes.

Ms O'BYRNE - So from Ambulance it would be tracked, because what I'm hearing back from EDs is that, because if people deteriorate they just get transferred in, there's no actual reclassification. It happens at the ED level. We'll see what we can go with that one.

My second question was around that example you gave for the northern region having an available roster of 40 per cent. Given that we have four ambulances, potentially five depending on what's available, what does that actually mean in terms of ability to respond if you have 40 per cent crew, because you may have somebody left on the ramp for hours taking care of somebody? What does it physically look like in terms of a response when you only have 40 per cent?

Mr DIGNEY - What they try to do is get people to come in on overtime, which quite often they're successful at doing, but that just exacerbates problems for the next day, because quite often they are paramedics who are rostered to work sometime in the next period. But essentially those paramedics who come in on overtime, decisions are made for them to work as a single officer. So instead of working as a crew, they will work them as a single officer, which means they're able to respond to emergencies, but they are not able to transport anybody.

So essentially what we saw on Saturday night in the northern region, they have a single officer, a single intensive care paramedic who is rostered to work alone to provide clinical support and high level interventions called the CRU, which is the Critical Response Unit, and then in the northern region, I think it's five crews, Michelle, around Launceston, so three are up at headquarters in Wellington Street and two are out at Mowbray. What we've seen at the commencement was one crew at Launceston, one crew at Mowbray and no other resources.

Ms O'BYRNE - There were at least three ambulances that we couldn't dispatch because of that?

Mr DIGNEY - And the Critical Response Unit, yes.

Ms O'BYRNE - That's actually quite disturbing.

Mr DIGNEY - Then, what happens is the branch stations that are adjacent to the urban areas - so for the purposes of the north that's Beaconsfield, Deloraine, George Town, Scottsdale, Longford - they get dragged into the urban area to provide the response in the busiest place, which of course leaves the rural area that they are meant to be covering uncovered.

CHAIR - It cannibalises the rural area.

Mr DIGNEY - Yes. It is just robbing Peter to pay Paul, Chair.

Ms O'BYRNE - Can I just finish that line of questioning?

CHAIR - Yes.

Ms O'BYRNE - So, in that case, when that's probably what they've had to do if they only had two staff ambulances - they've had to bring people in - are you aware of any impact in the regional communities or significant delays? Do you see spikes in response time delays as a result of that?

Mr DIGNEY - Absolutely. I think that it is well known.

Ms O'BYRNE - You can put it on the record, though.

Mr DIGNEY - Yes. I think it's well known that response times have increased dramatically. Whilst they do whatever is possible to make sure that category 1 response times are as low as they can be, because of course that is a life and death situation, we continue to hear reports. You see reports in the media. I am sure this committee has heard from patients and their families. I had a report to me from a member a couple of weeks ago where a young man had fallen and called an ambulance between 7.00 and 8.00 a.m. They responded to him after 3.00 p.m. and he had a broken pelvis.

Ms HAIGH - Also on top of that are the volunteer resources that are being used. So, for example, the branch stations work with a volunteer. Their job is not to come in and work in urban areas; theirs is just to look after their community. They're all being pulled in, expected to do - so when you get pulled into an urban area, you get the urban workload, and these people work all day and have their own lives. They choose to come in and help -

CHAIR - Need to pick up children from childcare or school.

Ms HAIGH - That's exactly right. They get caught up in this urban environment when they should be out looking after their own community.

CHAIR - Thank you. Mr Behrakis?

Mr BEHRAKIS - Thank you, Chair. I understand through EBA negotiations, there was a commitment to implement a transfer-of-care protocol.

Mr DIGNEY - Yes.

Mr BEHRAKIS - Can you outline HACSU's view on the progress of that? I think my understanding was that was to be in place within 12 months.

MR DIGNEY. Thanks for the question. Initially, the negotiations were a little bit fraught, to be quite honest with you. All the stakeholders were involved - the AMA, the ANMF, us, some various other stakeholders. It became pretty apparent after the first few meetings that there was no appetite for the other stakeholders to talk about a mandatory offload policy, because of course you are just shifting the patients who are currently stuck in an ambulance into ED, which itself is not actually the problem. It's the flow through there that's the problem. But recently we have been able to make some real progress with that protocol.

We have a draft protocol, which I will be able to provide to the committee. Ultimately, we're in the process of taking that out to our members to consult with. Once that consultation process is complete, our understanding is the Department of Health will then consult with the other stakeholders about the implementation of that protocol, which will see a maximum delay at the hospital of 60 minutes.

Just so we are clear, from our perspective that is only the first step. We want it to be 30 minutes, particularly for those higher acuity patients. But at this time we are encouraged by the Department of Health and their appetite to engage with us around that. It's the implementation and the consultation with other parties that it's going to affect greatly that makes us trepidatious and concerned about whether it will, in fact, be implemented.

Our members are really encouraged by it. The biggest concern is we are going to get to April or May when that's due to be implemented, they're not going to be in a position to implement it - the department - and our members are going to want to force it upon the department. What we want is a controlled implementation of that protocol. What we're concerned about is it's going to be a chaotic implementation of that protocol, because our members have made it clear 12 months is as long as they are going to wait for it.

Certainly, in other jurisdictions, for example, in the Australian Capital Territory 10 years ago, their ambulance service was negotiating with their Department of Health around a very similar mandatory off-load protocol. The Department of Health couldn't make that final hurdle. The paramedics up there did it by way of industrial action and it was a little bit chaotic to start with, but we have certainly heard from them as part of the negotiations and the work we've done on that protocol that it was only chaotic for a few weeks until everybody got their head around it. That's what happens now.

Mr BEHRAKIS - Where that's been implemented, that's worked better has it?

Mr DIGNEY - It hasn't dealt with the underlying resourcing issues but it has certainly freed up those ambulances to respond more timely to the community there.

CHAIR - It would be fair to say that there's a kind of de facto industrial action. It's not an industrial action but a similar effect is in place right now because paramedics are leaving and not turning up for shifts. So, we've already got a dramatic reduction on those very busy nights where the ambulances aren't available as they should be in the community because paramedics can't turn up. We are already in a situation where the crisis is here, isn't it?

Mr DIGNEY - Yes, that's right, Chair. If you look at some of the other data around how many patients are not actually transported to hospital these days because of community paramedics and other interventions that might be available - certainly if paramedics made a decision that if they respond to a case they are going to transport them to hospital then they could make matters worse very quickly.

CHAIR - In that comment, I, in no way, wanted to suggest that there was any direct agency or rationale for the fact that paramedics are burnt out and exhausted and can't turn up for shifts on Saturday nights. We have certainly heard from paramedics who have had that experience and they just can't do it. They just need a break.

Lucas, you could perhaps table those documents for the committee that you mentioned. The correspondence for the department. I've got some questions about data.

Mr DIGNEY -No worries. Chair, we have five pieces of correspondence that variously are directed towards either senior departmental officials, central government officials, and by that, I mean the State and Service Management Office, or Ambulance Tasmania executive management. All of these examples simply call for more resources.

CHAIR - Across what time period?

Mr DIGNEY - They commence in 2018 up to November last year. We would be able to provide another 100 examples but this just gives a good snapshot of the specific resourcing that we have asked for and the fact that we have got none of it.

CHAIR - Thank you.

Mr DIGNEY - If I can, Chair, I will also table our 2024-25 budget community consultation submission. The first five pages of that are around specific asks for ambulance resourcing.

CHAIR - Thank you. I wanted to ask you some questions about data systems and one of the terms of reference for the inquiry is about data collection and reporting for ramping. We are hearing there is a range of different systems that could be in use for patients as they move their way through the health system. What is your understanding of this and what effect does that have, the fact that there are multiple different systems?

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

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

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

CHAIR - Is this something that HACSU has pointed out to Ambulance Tasmania and if it is so fragmented, why do you think it has not been fixed?

Mr DIGNEY - Look, across the whole of health, Chair, not just in relation to ambulance but across the whole of health there is an issue with their standardised definitions, their real-time data collection, the number of different systems that are used across health. For example, Track-ED, which is the system that is used in the emergency department, is only used in the emergency department. The rest of the hospital does not use it. Up until recently, the rest of the hospital did not even have access to it.

CHAIR - So, this is the tracking of a patient in ED?

Mr DIGNEY - Yes.

CHAIR - But there is no tracking of a patient after ED and there is not a tracking of a patient before ED?

Mr DIGNEY - Well, there is, but it is not standardised with the way that they would be tracked through ED. So, there is a mismatch in the data. Then if you are trying to get an analysis on the mismatch of data, then it depends on who does that analysis as to what might be spat out the other end. If you are not collecting the same parameters, you sort of have to make assumptions and we are all clear on what happens when you are making assumptions about data: you can just have incorrect reporting on it. It is certainly an issue about getting the extent of the problem and quantifying it down to the minute in terms of how long a patient might be ramped, or how long the delay of care actually is, because it is not really recorded until the triage nurse or the nurse in charge says this patient is going to be delayed.

CHAIR - Why do you think it has not been fixed?

Mr DIGNEY - I think that there is a range of competing priorities for the Government, Chair, but ultimately it has not been fixed because it has not been a priority to be fixed. Any problem that the Government has can be fixed if they make it a priority to fix it.

CHAIR - The Safety, Learning and Reporting System (SLRS), we have heard evidence from other people about their concerns about the system. Do you think the system is well designed to allow people to report safety incidents?

Mr DIGNEY - No. In short, Chair, we think the system is junk. It is clunky. It is hard to create a concise and timely report. So for our members who are in a paramedic truck, they have to log on to their computer. They cannot do it on their phone. If they can, it is very clunky and it is very difficult to record all the necessary data. Our biggest concern is a lot of those SLRSs are able to be reviewed by people in the management line and essentially killed before they make it to executive management or senior management level.

CHAIR - So, what actually happens then, when paramedics lodge an incident with the SLRS about ramping?

MR DIGNEY - It will be reviewed by somebody unknown at some point in time.

CHAIR - Is there a feedback to the person who has made the report?

Ms HAIGH - There is supposed to be, but a lot of the time it just comes back, your case is closed. They have improved that over the last couple of years, but you do not necessarily get feedback on your report.

CHAIR - So, there is no reporting on their reporting to SLRS?

Ms HAIGH - Not that I am aware of.

Mr DIGNEY - No. They produce data about how many they might have had and what level of serious incidents might have been recorded in those SLRSs but ultimately it is a safety reporting system that is well past time for being replaced.

CHAIR - What do you think it needs to be replaced with?

Mr DIGNEY - It needs to be replaced with a system where all employees, in this case our members in Ambulance, can make a timely report and that report goes to a central location

and is reviewed by people who have the necessary qualifications to judge whether it is low-, medium- or high-risk. We also want a system where the outcome of that report is reported back to the person who actually made it in the first place. Simply to receive an email saying, 'Your safety report is now closed', and a reference number is totally inadequate.

CHAIR - Some of them could be on very serious matters.

Mr DIGNEY - Absolutely. In our view, it leaves the Government hopelessly exposed on workplace health and safety.

Ms DOW - There's been a lot of discussion around the uncertainty that short-term contracts have on paramedics across Tasmania. Could you update the committee on that, your understanding of where the positions that have recently been advertised by the Government are at, and talk more about the impact that has on the workforce and retention in particular?

Mr DIGNEY - Thanks, Anita. The use of fixed-term employment is a real scourge. It's a scourge across the State Service. But it's particularly a scourge in output areas like Ambulance Tasmania, where it's our view that you could recruit qualified paramedics on an ongoing basis and never run the risk of being overstaffed. Such is the turnover of that cohort of workers that the only risk you really run by doing that is possibly having to pay a redundancy should you get to the point where you are over establishment. But because of the approvals process for not only executives in Ambulance Tasmania but officials in the Department of Health, it has been overused as a matter of convenience because they can simply get those things approved faster than they can get a full-time or permanent position approved. But what it does is it leaves people in insecure employment.

I'm sure the committee has heard that there is an undersupply of qualified paramedics across the country. Every ambulance service across the country is recruiting and some of the services, particularly in New South Wales and Victoria, are running massive recruitment programs at the moment. If you're a qualified paramedic who works in Hobart and you've been on a fixed-term contract for 12 months, then you're rolled onto another fixed-term contract, and there's no indication that full-time employment is going to be forthcoming. If there's a permanent job for a paramedic in Victoria, you don't have to have any type of university qualification to work out that that person is most likely going to Victoria if they're offered a full-time job.

Increasingly, what we see is people will take up a fixed-term position, even though they have a permanent position as a paramedic but then they are unable to backfill the paramedic's job because there's no contingency in the system to backfill that position, and, of course, very few people are interested in fixed-term employment. If you advertise a fixed-term job, quite often nobody wants it because it's insecure. The number is unknown, to be quite frank with you, but we still have tens of positions across the state, both at an operational paramedic level and throughout the management, clinical support and other support area chain, that are currently fixed-term. It's hard to even quantify what the service looks like in terms of establishment and full-time positions when, in essence, you've got to follow this ball-and-cup trick around: is that a permanent position, is that a fixed-term position, do we have an incumbent who is meant to be in that position who is on worker's comp or been seconded to another area or is, in fact, themselves in another fixed-term position? It's a total mess, to be quite frank with you.

CHAIR - Are you saying that we don't know how many positions in Ambulance Tasmania are fixed-term and what types of positions?

Mr DIGNEY - Certainly, they would know how many fixed-term employees they have from week to week. But what I mean is, for example, if Simone is a permanent intensive care paramedic but then she takes a fixed-term role as a clinical support officer because the incumbent in the clinical support officer position has, in turn, taken a fixed-term position as an ambulance manager, then it's hard to know. We've got one, two fixed-term employees but neither of them are actually fixed-term employees; they're both permanent employees but neither of them are in their permanent position. So, when you are asking for data, it's honestly like trying to follow a charlatan at a carnival show. You just can't make hide nor hair of it.

CHAIR - Through the committee, we've received a range of information from the Government about ambulance ramping but the Government doesn't regularly report any data about ambulance ramping. Do you have a view on whether this should be happening?

Mr DIGNEY - I think that the community has a right to know how long their ambulances spend on a ramp at a hospital, given that it's not what the community pays for their ambulance service to do. The community expects the ambulance service to be able to provide a response to an emergency medical situation in the community. If they are sitting on a ramp at a hospital, then they are simply unable to do that. I think they should be reporting on that in real time to the extent that they can.

CHAIR - We know from research that has been done in other states, in Victoria, that there are adverse outcomes. You've already described the experiences of members. We've heard that. But the research also backs up that there are adverse outcomes the longer people are ramped. Have you got access to the ambulance ramping data from the Government?

Mr DIGNEY - We receive a monthly activity report. That does have some data in it relating to the total time ambulances have spent ramped by region. But, ultimately, that's the total time for the reporting period, which is a month, so we don't get anything other than anecdotal evidence of what's going on on a day-to-day basis.

CHAIR - That information isn't available to the public. How did you get the Government to agree to give that to you?

Mr DIGNEY - Over time and with the evolution of right to information legislation, we've taken it upon ourselves to make applications for what should be publicly available information. It's our view that, because of our willingness to do that, they have begrudgingly agreed to provide us that data. What we say is they do that so we don't make right to information applications for it because, if we did, they would have to publish it on the Right to Information website.

CHAIR - Are you allowed to share that information publicly since you've been given the information? It is public information?

Mr DIGNEY - There's no rules to stop us doing that but they've made it clear to us that they're not comfortable with us sharing it. They've implied that if we do share it, that information flow may well cease.

CHAIR - What is their reason for not wanting to make it available, or for you to make it available to anyone else?

Mr DIGNEY - I think it's clear: because it's pretty damning data which shows the amount of times that ambulances aren't available to respond to emergencies in the community.

CHAIR - How do you think people would feel in the community if they saw that information? Other states provide real-time information. Is that something that you would recommend for Tasmania?

Mr DIGNEY - I think that the Tasmanian Government has had an issue with transparency and has done for quite some time, Chair, and I think that all of that data should be publicly available and it should be published on a Health dashboard, if you like, that's available to the public so they can see what the state of their health system actually is.

CHAIR - Would that be a real-time dashboard?

Mr DIGNEY - Even if there was a lag in the data - even if they're reporting month by month so you can only really see last month's data because, as we've described, their data collection and reporting certainly needs some reform before they're in any position to do it in real time. But even if they're reporting that data to the community that we receive, then that's better than what they're doing now.

CHAIR - We have to wrap up now, but I wanted to talk to you about some of your suggestions for solutions. We've heard that you've been pressing the Government for years now and proposing solutions, and we've heard that the Government hasn't taken up the solutions and recommendations that you've been proposing. I want to go to the scenario where there is little action from the Government on this situation. In your view, what would happen over the next few years if the trend that we see at the moment was to continue?

Mr DIGNEY - It will simply get worse, and it will lead to catastrophic outcomes for patients, Chair. It's that simple. We're already seeing adverse outcomes for patients. We know that patients have died while they've been ramped at our hospitals, and what the Government can expect is that to increase and continue. They will likely also see greater pressure on their ambulance workforce, because more people will simply refuse to be engaged in that type of work.

CHAIR - Can you break down some of the solutions into some of the bigger actions and then, maybe, could you talk about some immediate steps? You have already mentioned one of the immediate steps.

Mr DIGNEY - What's going to solve it in the long term and permanently, Chair, is investment in primary and community health. There are too few allied health professionals in Tasmania for the population and the general wellbeing of the population. The statistics are clear about that. There are too few general practitioners and nurse practitioners and rural generalists available in Tasmania, and because of that, what we see is members of the community become unwell to a point where they never should have got if there had been adequate primary intervention, which sees them having no other choice but to call an ambulance or present to an emergency department.

Whilst some of that responsibility, particularly around general practitioners, sits with the federal government, it's unclear what the state is doing to pressure their federal counterparts to fix that situation. Certainly, if any government wants a long-term and lasting solution to ambulance ramping and to capacity constraints and bed block in ED, then they have to make that investment, and if they don't, then they can expect the current situation to worsen because, ultimately, sick Tasmanians have very little choice at the moment. If you are not on a GP's books or you're not already in a community health service's round of patients, you're not going to get on their books or into that round and, ultimately, your condition will just get worse and worse and you'll get sicker and sicker until you end up in hospital.

Ms HAIGH - On top of that, it even goes before that - a lot of funding has been cut out of preventative health and put into chronic health. If you take out preventative health, you will get stuck with -

CHAIR - It becomes chronic.

Ms HAIGH - It becomes chronic, exactly. That's too late dealing with people with chronic health. It should be preventative. We also have intergenerational poor health literacy. Tasmania has some of the most disadvantaged areas in the country when it comes to the social determinants of health, and we need to be looking out for these people and educating them on all sorts of stuff. There is a lack of transport, smoking, drinking, lack of education. All these things compound that health illiteracy and that lack of understanding, lack of preventative health that then ends up with chronic diseases such as emphysema, diabetes, all those things that can be prevented, but there's a lack of education and understanding in these early areas and it just becomes, as I said, inter-generational.

If we can get investment into these areas and community health and primary health you'll find that there'll be less presentations to hospital and ambulances won't be having to deal with all of this chronic illness, who cannot get into a GP, who then progressively get worse and worse and then call an ambulance and end up in our EDs. When really, if they'd been able to go to a GP it could be managed sooner and they wouldn't have been sick enough for us to come and then to go to hospital.

It is a wholistic approach to health and it all has a knock-on effect. We need to look at the health system as a whole and really invest properly into that. Stop with the efficiencies and start actually investing into health.

Mr DIGNEY - That flows into some immediate solutions, Chair, that could be considered by the government. For example, in the northern region we know that there's a ward at Scottsdale Hospital that is currently used to store beds and other equipment. We know that there are 10 acute beds available at Deloraine Hospital but they've been shut and they've been shut for a number of years. Some of the overflow, some of the people who cause the flow issues in our larger tertiary hospitals could be moved to those rural and regional hospitals and cared for adequately there, which would free up bed space in the larger tertiary hospitals which would mean some of that blockage that we see in our EDs would be alleviated.

Is it enough to take the entire pressure of the system? That's unclear, but there is capacity that is immediately available, as we speak, in some of those rural and regional hospitals and as I understand it, some of those rural and regional hospitals won't even take patients who are category 2. They only take category 3 and below patients, which - I'm not a clinician - so that's

for someone who is far more qualified than me to make the assessment about. But I would have thought in a hospital where you have registered nurses and other registered health professionals and doctors working that they would be adequately to care for any category of patient, of course, the high acuity of patients and sick patients we'd certainly want in our larger tertiary centres, but the utilisation of rural and regional hospitals is not at 100 per cent and until it is, we have to take the position that the capacity constraints relate to budgetary control measures rather than anything else.

CHAIR - We could keep talking for a long time but I thank you for your testimony today. It has been so helpful to the committee. Your voice is really important and I also want to acknowledge the advocacy that you do and have done for years on this issue. The job of the committee now is to really make some concrete recommendations and to make some recommendations for positive change and immediate, medium and long-term changes to improve the situation.

On behalf of the committee, thank you for coming in today. Before you leave I just want to ask you whether you remember and understand parliamentary privilege that you have been able to be free and frank in here which is great for the work of the committee but after you leave the room that privilege doesn't follow you out the door. Do you understand?

Mr DIGNEY - Fully understood.

Ms HAIGH - Yes.

CHAIR - Thank you so much, Simone and Lucas, for coming in today.

THE WITNESSES WITHDREW

The committee adjourned at 2.04 p.m.