LEGISLATIVE COUNCIL

PORTFOLIO COMMITTEE NO. 2

Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Report 60

2

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Portfolio Committee No. 2 - Health

Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

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Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

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Chair: The Hon. Greg Donnelly MLC

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Terms of reference

1. That Portfolio Committee No. 2 - Health inquire into and report on the impact that ambulance ramping and access block is having on the operation of hospital emergency departments in New South Wales, and in particular:

   (a) the causes of ambulance ramping, access block and emergency department delays;

   (b) the effects that ambulance ramping and access block has on the ability and capacity of emergency departments to perform their function;

   (c) the impact that access to GPs and primary health care services has on emergency department presentations and delays;

   (d) the impact that availability and access to aged care and disability services has on emergency department presentations and delays;

   (e) how ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff;

   (f) the effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays;

   (g) drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider to address the impact of ambulance ramping, access block and emergency department delays; and

   (h) any other related matters.

The terms of reference were self-referred by the committee on 26 July 2022.[1]

[1] *Minutes*, NSW Legislative Council, 9 August 2022, pp 3549-3550.

Committee details

Committee members

The Hon Greg Donnelley MLC	Australian Labor Party	*Chair*
The Hon Emma Hurst MLC	Animal Justice Party	*Deputy Chair*
The Hon Lou Amato MLC	Liberal Party	
Ms Cate Faehrmann MLC	The Greens	
The Hon Wes Fang MLC	The Nationals	
The Hon Aileen MacDonald MLC*	Liberal Party	
The Hon Walt Secord MLC	Australian Labor Party	

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* The Hon Aileen MacDonald MLC replaced the Hon Chris Rath MLC as a substantive member of the committee from 16 August 2022.

Chair's foreword

It is widely accepted in the community that a government's greatest responsibility is to the health of its citizens. New South Wales is not atypical in allocating a significant part of its budget to health. This inquiry examined what the health sector calls 'patient flow'. That is, the journey a patient takes from calling 000 or presenting at an emergency department (ED), through to being treated and in many cases admitted to a bed on a ward, to finally being discharged from the hospital.

Problems with patient flow can occur anywhere in the health system. Stakeholders were clear in explaining to the committee that the issue is not simply with ambulances, EDs and hospital beds, meaning that a blockage in one part will cause blockages elsewhere in the system. The inquiry examined the main parts of the health system where problems, and therefore solutions are to be found.

The committee examined the structural issues that contribute to problems with patient flow. First and foremost, hospital occupancy rates are too high. When hospitals operate constantly at 100% occupancy, they cannot admit patients from EDs during 'surge' periods or times of unexpected demand. As well, an ED operates 24 hours a day, seven days a week, while the rest of the hospital operates for considerably fewer hours.

This has a flow-on effect throughout the system. If patients cannot be transferred from an ED to an inpatient bed at the appropriate time, EDs become overcrowded. This in turn means that ambulances cannot offload their patients, which causes ambulance ramping.

Another factor impacting on patient flow is primary care, in particular access to GPs and other services, including mental health services. It is true that 'low-acuity' patients do not take up significant resources in EDs, although they can contribute to overcrowding. The main issue is people who cannot access primary care when they need it deteriorating before presenting to an ED as 'high-acuity' patients. Treating people early and 'in place' not only ensures a better health outcome for patients, it also places less strain on the health system.

Similarly, many aged care residents and NDIS clients currently cannot access the treatment they need in their homes or in the community. This problem is exacerbated when patients are ready to be discharged from a hospital but do not have an appropriate place to return to or will not be able to access the ongoing medication and treatment they need. This cohort is remaining in hospital beds longer than they should have to – this is known as 'bed block' – another contributing factor to ED overcrowding and ambulance ramping.

Primary care, aged care and the NDIS are Commonwealth responsibilities, yet clearly how these areas function and operate has a major impact on the New South Wales health system. The fragmented approach to health between the Commonwealth and States/Territories has long been acknowledged as problematic. It is therefore important that the New South Wales Government continues working closely with the Commonwealth to help keep people unnecessarily out of hospital while also ensuring patients are not kept in hospital any longer than required.

At the heart of this inquiry was the impacts that patient flow problems have on both patients and staff. Patients are suffering because their care is compromised by a health system that is not functioning as well as it should. The committee heard troubling examples about patients' health deteriorating in ambulances and overcrowded EDs or suffering a loss of dignity through being treated in inappropriate spaces.

The committee was also concerned about staff, who have already given so much during the COVID-19 pandemic and the ongoing natural disasters. After all, without healthcare staff there is no health system. A number of witnesses to the inquiry expressed the opinion that staff wellbeing is declining. The committee heard from many witnesses that staff are under increasing pressure every day, working excessive overtime, missing meal breaks and in some cases not being able to take-off paid leave like annual leave. Sadly, we heard that many healthcare staff are ending their shifts concerned that they have not provided patients with the level of care that they are trained to, and want to provide.

The committee would like to assure all healthcare staff that it understands that the problems and challenges with the health system are outside of their control. That is why the committee has made several targeted recommendations it believes will help provide staff with greater influence over their circumstances at work. For example, the committee based on the evidence provided to it during the inquiry, believes that both paramedics and pharmacists are willing and are in a position to do more to help improve patient flow in public hospitals.

The committee also acknowledges evidence that New South Wales is losing staff to other States/Territories offering better pay and working conditions. The committee has therefore recommended that the Government abolish the wage cap on state sector employees, including junior doctors, paramedics, nurses, midwives and other healthcare staff. This is the best way of delivering fair wages, productivity growth and improved public services for all citizens across New South Wales.

In assisting to help tackle the matters raised in this inquiry, the committee has recommended that all public hospitals have sufficient staffed beds to function at around 85% occupancy rate. The committee heard from various witnesses that this is the figure that will help ensure patients can be transferred from EDs to hospital wards and a bed when they are ready, thereby reducing overcrowding in EDs and, as a result, ambulance ramping.

The committee also considered what NSW Health is currently doing to improve patient flow. There is no doubt that NSW Health is aware of the issue and is working to improve the situation for patients and staff alike. However, the committee remains unconvinced that NSW Health understands just how difficult the problem is in some hospitals, or has a clear line of sight into exactly where the system is not properly integrated.

A health system that is not properly integrated cannot function as well as it should. The committee therefore recommended that NSW Health create a dedicated position with responsibility for patient flow across the whole of the health system. This person's role should include identifying and responding to system-wide issues that negatively impact on patient flow in public hospitals.

Patient flow is a whole-of-system issue, requiring a whole-of-system response. The health system in New South Wales can and should be functioning much better. The committee believes that the implementation of the recommendations in this report will assist the health system operate at a higher level of functionality i.e. provide patients with the right care, at the right time, in the right place.

Finally, the committee thanks all those who participated in this inquiry through their submissions and oral evidence. I also wish to acknowledge and thank my committee colleagues for the collegiate way in which they have engaged and participated in this important inquiry. Can I, on behalf of the whole committee, thank all the hardworking and dedicated staff employed by NSW Health who have worked tirelessly over the last almost three years to provide outstanding care and support to the citizens across the state in the most difficult of circumstances. Finally, can I thank all the Committee Secretariat and Hansard staff for their hard work and professionalism, without which this report could not have been produced.

Hon Greg Donnelly MLC
Committee Chair

Recommendations

Conduct of inquiry

The terms of reference for the inquiry were self-referred by the committee on 26 July 2022.

The committee received 35 submissions.

The committee held two public hearings at Parliament House in Sydney.

The committee was briefed by Professor Paul Middleton, the external subject matter expert on 19 September 2022.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents and answers to questions on notice.

Chapter 1 Overview

This chapter introduces the main issues addressed in this inquiry: ambulance ramping, emergency department (ED) overcrowding and access block. It then explains how responsibility for the health system in Australia is shared between the Commonwealth and States/Territories and the concept of patient flow. For this report, the committee considers the health system to include: primary care (e.g. GPs and allied health services); aged care and disability services; ambulances; and hospitals (EDs and wards).

The chapter concludes by revealing where in the system problems occur, comparative data showing the current performance of the health system, and how New South Wales performs compared to other states and territories.

Definitions

1.1 The committee used the commonly accepted following definitions from the Australasian College for Emergency Medicine (ACEM).[2] Throughout this report, witnesses frequently refer to ambulance ramping, emergency department (ED) overcrowding and access block collectively.

Ambulance ramping

1.2 Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED.

1.3 Ambulance off-loading refers to an agreed process between ambulance services and ED staff when transferring patients from the ambulance stretcher into an appropriate area within the ED.

1.4 Other terms commonly used include 'patient off stretcher time delay' or 'offload delay'[3] and 'transfer of care [the process of moving a patient from an ambulance to an ED] delays.'[4]

Emergency department overcrowding

1.5 Emergency department overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical or staffing capacity of the ED, whether patients are waiting to be seen, undergoing assessment and treatment, or waiting for departure to go onto a ward or leave the ED having been discharged.

2 Submission 16, Australasian College for Emergency Medicine, p 2.

3 Submission 28, Australasian College of Paramedicine, p 1.

4 Evidence, Ms Sophie Dyson, Director, Taylor Fry Pty Ltd, 7 October 2022, p 25.

Access block

1.6 Access block (or bed block) refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED, whose total ED time exceeds eight hours because of a lack of inpatient bed capacity. This includes patients who were planned for an admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED.

How responsibility for health is shared across Australia

1.7 Responsibility for funding and regulating the health system is shared between the Commonwealth and the States/Territories. Relevant to this inquiry, the Commonwealth is responsible for:

- Medicare
- the Pharmaceutical Benefits Scheme (PBS), which subsidises universal access to prescription medicines
- subsidies for and regulation of aged care services
- education of health professionals through Commonwealth-funded university places
- expanded after-hours GP and primary care services
- national coordination and leadership.

1.8 States and territories are mainly responsible for:

- management and administration of public hospitals
- delivery of preventive services such as breast cancer screening and immunisation programs
- funding and management of community and mental health services
- ambulance and emergency services
- patient transport and subsidy schemes.

1.9 The Commonwealth and the States/Territories share responsibilities across several areas, including:

- funding of public hospital services based on an agreed national activity-based funding formula as outlined in the National Health Reform Agreement
- preventive services, such as free cancer screening programs including those under the National Bowel Cancer Screening Program
- shared funding of palliative care
- national mental health reform

- responding to national health emergencies.[5]

Increased demand and funding

1.10 Demand for health services, including emergency medical care, has grown over the past decade. In the second quarter of 2011 (April to June) there were 500,242 ED presentations in New South Wales. By the first quarter of 2022 (January to March), ED presentations had increased to 716,288, an increase of just over 40 per cent.[6]

1.11 NSW Health informed the committee that since March 2011, recurrent funding for the New South Wales public health system has increased by more than $15.2 billion, up from $15.5 billion. Expenditure on health accounts for 25.5 per cent of the NSW Budget.[7]

Patient flow

1.12 The term 'patient flow' refers to how patients move between the different parts of the health system. Put simply, patients attend EDs either via ambulance or by self-presenting. They are assessed and treated and either discharged or sent to a hospital ward. If no beds are available on a ward, patients are required to stay in the ED. Patients are sometimes located nearby but not strictly within the ED. For example, they may be left in a corridor or a hallway while waiting to be admitted to a ward.

1.13 Assessment, or patient triage, is complex task that assigns priority to patients using the Australian Triage Scale (ATS), a five-level scale with one being the highest and most urgent. Patients arriving by ambulance are generally prioritised over self-presenting patients to allow ambulances to respond to more calls. Ambulance patients also tend to be in the higher acuity triage categories. Patients are sent to a section of the ED based on their ATS number and the urgency of their symptoms.

1.14 Professor James Mallows informed the committee that patients whose symptoms require constant monitoring or treatment cannot be offloaded from the ambulance and will need an acute care bed. He said: 'Therefore, the degree of ramping will depend on the degree of patient flow through acute care … The majority of patients that require an acute care bed for the assessment and treatment within the ED usually require admission to the hospital.'[8]

1.15 Consultancy firm Taylor Fry provided the committee with data on ambulance, ED and public inpatient workload in New South Wales in 2020-21:

- patients are transported to hospital in 71 per cent of NSW Ambulance incidents
- 23 per cent of ED arrivals in New South Wales are by ambulance

5 Parliament of Australia, Parliamentary Library, *Health in Australia: a quick guide* (31 August 2018), https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust#_Which_level_of

6 Submission 35, NSW Health, pp 4-5.

7 Submission 35, NSW Health, p 31.

8 Submission 26, Professor James Mallows, pp 2-4.

- 24 per cent of ED presentations are admitted to (the same) hospital, with the majority discharged home, to another hospital or usual place of residence
- admissions from ED make up 39 per cent of public hospital inpatients, with most admissions planned. 'Planned' or non-emergency admissions includes those initiated by an ED visit but not admitted directly from ED.[9]

Ambulance ramping and access block: where and how big is the problem?

1.16 Ambulance ramping and access block are distinct but related issues that reflect problems across the whole health service. These problems start with the reasons why patients attend EDs. They then continue to include ED overcrowding, staffing, the number of available beds in hospital wards and delays for patients ready to be discharged from hospital. All of these factors are examined in the following chapters of this report.

1.17 Numerous witnesses presenting at the public hearings held by the committee similarly described these problems as a 'symptom' of a much broader issue.[10]

1.18 Evidence shows the cause-and-effect nature of this issue; that is, access block causes ambulance ramping. Professor James Mallows told the committee that every morning most EDs in New South Wales have many patients waiting to be admitted to hospital. In his submission, Professor Mallows wrote:

> … if you have an ED with 21 acute care bed spaces and you have 18 admitted patients at 8 AM waiting for a ward bed, you are functionally working with a three bed ED as the 18 patients are actually ward patients. There are hospitals in the Sydney metropolitan area where ward patients boarding in the ED exceeds the total number of ED acute care bed spaces. In this situation the ED is operating with a negative bed base.[11]

1.19 This means that ambulances will have nowhere appropriate to offload their patients. Less serious patients may be placed in a chair wherever there is space – including hallways – while more serious patients that require constant monitoring will remain in the ambulance until a bed becomes available. This is how access block causes ambulance ramping.

1.20 Dr Claire Skinner from ACEM explained that the reason EDs are almost always busy no matter the time of day '… is because of lack of capacity during the day. So the patient numbers build up and then it's often standing room or sitting room only for anyone who is admitted during the night shift, with minimal staff on.'[12]

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9 Submission 23, Taylor Fry Pty Ltd, p 3.

10 See for example: Evidence, Mr John Bruning, Chief Executive Officer, Australasian College of Paramedicine, 5 October 2022, p 14; Evidence, Mr Gerard Hayes, Secretary, Health Services Union (NSW/ACT/QLD), 5 October 2022, p 41; Evidence, Dr Jaqueline Huber, Fellow, Royal Australian and New Zealand College of Psychiatrists, 5 October 2022, p 57; Evidence, Associate Professor James Mallows, Staff Specialist Emergency Physician and Director Emergency Medicine Research, Nepean Hospital, 7 October 2022, p 16.

11 Submission 26, Professor James Mallows, p 5.

12 Evidence, Dr Clare Skinner, President, Australasian College for Emergency Medicine, 5 October 2022, p 7.

1.21 The Health Services Union (NSW/ACT/Qld) described the problems of ambulance ramping and access block as 'a symptom [reflecting] a public health system failing as the result of years of neglect.'[13]

Is this a growing problem?

1.22 Ambulance ramping is an issue in both metropolitan and regional New South Wales. Dr Sue Velovski, a General Surgeon and committee Member, Rural Doctors Association NSW, said:

> For us as both local community members and clinicians, ambulance ramping is not new. Overcrowded emergency departments have been a feature of the healthcare system for many years … Over the many years that I've worked as a specialist, as a surgeon, it's only become worse.[14]

1.23 Other stakeholders also told the committee that the problem is both not new and getting worse. Mr Scott Beaton from the Australian Paramedics Association stated that the problem was noticeably bad in the early 2000s before improving in subsequent years. However, 'it's probably at its worst at the moment.'[15]

1.24 The Chief Executive of The Council of Ambulance Authorities, Mr David Waters, said: 'From my perspective, yes, it is increasing [and] is increasing across all jurisdictions.'[16]

1.25 Dr Pramod Chandru, an emergency medicine specialist and consultant at Westmead and Nepean Hospitals, said: 'I cannot remember a time in the recent past—I would extend that to anywhere between five to seven years—where I have practised in an emergency department with appropriate access and flow.'[17]

1.26 It is evidence such as this that led witnesses to describe ambulance ramping, ED overcrowding and access block as the 'new normal'.[18]

1.27 The key findings from the most recent Healthcare Quarterly data (April – June 2022) at the time of writing this report from the Bureau of Health Information (BHI) show how ambulances and EDs are currently performing in New South Wales compared to past years.[19]

Ambulances

- There were 375,215 ambulance calls and 333,927 responses, up 21.1 per cent and 7.8 per cent, respectively, compared with April to June 2019. The gap between the number of ambulance calls and responses has been increasing since late 2019.

13 Submission 34, Health Services Union (NSW/ACT/Qld), p 12.

14 Evidence, Dr Sue Velovski, General Surgeon, Ballina and Lismore and committee member, Rural Doctors' Association of NSW, 5 October 2022, p 49.

15 Evidence, Mr Scott Beaton, Station Officer - Central West and Vice President, Australian Paramedics Association (NSW), 5 October 2022, p 15.

16 Evidence, Mr David Waters, Chief Executive, The Council of Ambulance Authorities Inc, 5 October 2022, p 27.

17 Evidence, Dr Pramod Chandru, Emergency Medicine Staff Specialist, 5 October 2022, p 34.

18 Evidence, Dr Skinner, 5 October 2022, p 3; Evidence, Dr Chandru, 5 October 2022, p 34.

19 Bureau of Health Information, Healthcare Quarterly April – June 2022.

- There were 12,134 priority 1A (P1A) responses to patients with life-threatening conditions, up 85.2 per cent compared with 2019 and the highest since BHI began reporting in 2010. The weekly number of P1A responses was almost double 2019 levels throughout May and June.
- The percentage of P1 cases with a call to ambulance arrival time within 15 and 30 minutes was 35.0 per cent and 77.3 per cent, respectively – the lowest results since 2010.
- The percentage of P1A responses within 10 minutes was 57.6 per cent – the lowest since 2010. Half of these patients waited longer than 9.1 minutes – the longest since 2010.
- For half of P1 cases, patients waited longer than 16.3 minutes – the longest since 2010.

Emergency departments

- There were 793,987 ED attendances, up 5.2 per cent compared with April to June 2019. Triage category 2 presentations reached 110,942 – the highest of any quarter since BHI began reporting in 2010.
- 62.8 per cent of all patients, and 51.6 per cent of triage 2 patients, had their treatment start on time. Both were the lowest of any quarter since 2010.
- 178,490 patients were treated and admitted to hospital, down 8.2 per cent compared with 2019. 76,117 patients left without, or before completing, treatment – up 67.6 per cent compared with 2019 and more than any quarter since 2010.
- 23.0 per cent of patients who were treated and admitted to hospital spent less than four hours in the ED. One in 10 patients who were treated and admitted, spent longer than 21 hours and 16 minutes in the ED – the longest of any quarter since 2010.
- 72.5 per cent of patients who arrived by ambulance had their care transferred to ED staff within 30 minutes – the lowest since BHI began reporting this measure in 2013. One in 10 patients waited longer than one hour 11 minutes to be transferred – the longest since 2013.

1.28 Some witnesses attributed the worsening situation to the impact of COVID-19 on the health system.[20] This is because of several factors related to the COVID-19 pandemic, mainly:

- the number of patients with COVID-19 in hospitals
- more patients presenting at EDs with severe respiratory problems
- staff shortages because of large numbers being furloughed.

1.29 The Secretary of NSW Health, Ms Susan Pearce, told the committee that she first observed problems with patient flow in the late-2000s. She said that NSW Health began to take 'very strong action' to address this issue in 2015, which produced consistent improvements until new challenges arose in 2019. Ms Pearce acknowledged the stress the health system is currently under, however despite these challenges said that 'we are regarded as the best health system in the country and we are one of the best health systems in the world.'[21]

20 Submission 33, Australian Medical Association (NSW) Ltd, p 3.

21 Evidence, Ms Susan Pearce, Secretary, NSW Health, 7 October 2022, pp 32-33.

1.30 When asked whether it acknowledged ambulance ramping as a common occurrence in New South Wales, NSW Health responded:

> Transfer of care performance of the NSW Health system is not static and can vary on a day-to-day basis. The NSW Government is committed to increasing the capacity of NSW Ambulance and public hospitals having built or upgraded more than 180 health facilities since 2011, with more than 130 projects currently underway. This includes 73 ambulance stations which have been delivered or are being delivered as part of the Rural Ambulance Infrastructure Reconfiguration (RAIR) program and the Sydney Ambulance Metropolitan Infrastructure Strategy (SAMIS). The NSW Government has also allocated $1.76 billion to boost frontline emergency care, which will support an additional 2,128 paramedics and control centre staff.[22]

1.31 Several stakeholders referred to Healthcare Quarterly data when reflecting on trends in the performance of ambulance service and emergency departments. The committee has reproduced the following data from 2015 to 2022 below. According to stakeholders, the data suggests:

- there was an overall improvement in ambulance and ED performance from 2015 to 2018 when a decline can be seen in line with an increased number of presentations
- the arrival of COVID-19 in 2020 initially saw a large decrease in presentations and accompanying improvement in performance, followed by a decline in performance as numbers rose again from 2021.

Emergency Department presentations: Overall/by ambulance

- April – June 2022: 793,987 / 174,541
- April – June 2021: 807,023 / 179,813
- April – June 2020: 615,690 / 153,605
- April – June 2019: 754,462 / 173,437
- April – June 2018: 697,623 / 157,376
- April – June 2017: 663,942 / 146,483
- April – June 2016: 637,207 / 140,338
- April – June 2015: 628,525 / 138,486

Percentage of patients transferred from ambulance to ED within 30 minutes

- April – June 2022: 72.5 per cent
- April – June 2021: 78.7 per cent
- April – June 2020: 93.2 per cent
- April – June 2019: 87.6 per cent
- April – June 2018: 91.6 per cent
- April – June 2017: 91.8 per cent

[22] Answers to questions on notice, NSW Health, 8 November 2022, p 3.

- April – June 2016: 91.2 per cent
- April – June 2015: 85.0 per cent

Time to start treatment: All patients percentage starting treatment on time

- April – June 2022: 62.8 per cent
- April – June 2021: 67.4 per cent
- April – June 2020: 84.2 per cent
- April – June 2019: 71.9 per cent
- April – June 2018: 76.6 per cent
- April – June 2017: 75.6 per cent
- April – June 2016: 76.4 per cent
- April – June 2015: N/A

Percentage of patients who spent four hours or less in the ED

- April – June 2022: 57.6 per cent
- April – June 2021: 64.7 per cent
- April – June 2020: 70.5 per cent
- April – June 2019: 71.8 per cent
- April – June 2018: 74.0 per cent
- April – June 2017: 73.8 per cent
- April – June 2016: 73.9 per cent
- April – June 2015: 73.3 per cent

Ambulance: April to June 2022

- In April to June 2022, the percentage of P1A responses within 10 minutes was 58.9 per cent in urban areas and 54.7 per cent in rural areas.
- In April to June 2022, the percentage of P1 cases with a call to ambulance arrival time within 15 minutes was 31.9 per cent in urban areas and 42.6 per cent in rural areas. The percentage of P1 cases with a call to ambulance arrival time within 30 minutes was 75.9 per cent in urban areas and 80.7 per cent in rural areas.[23]

Call to ambulance arrival time: P1 cases within 15 minutes

- April – June 2022: 35.0 per cent
- April – June 2021: 47.9 per cent
- April – June 2020: 61.3 per cent

[23] In New South Wales, category P1A is classified as 'Highest priority' and P1 is classified as 'Emergency'.

- April – June 2019: 59.1 per cent
- April – June 2018: 62.3 per cent
- April – June 2017: 63.7 per cent
- April – June 2016: 64.4 per cent
- April – June 2015: N/A

Response time: P1 cases median

- April – June 2022: 16.3 minutes
- April – June 2021: 13.4 minutes
- April – June 2020: 11.2 minutes
- April – June 2019: 11.6 minutes
- April – June 2018: 11.2 minutes
- April – June 2017: 11.1 minutes
- April – June 2016: 10.9 minutes
- April – June 2015: N/A

New South Wales is performing better than other states and territories

1.32 It is important to note that ambulance ramping and access block are not unique to New South Wales, with the same ongoing problems presenting in equivalent health services across Australia and many other countries around the world (such as the United Kingdom and Canada).

1.33 The committee heard that despite the worsening situation over recent years New South Wales performs better than other states and territories across many performance measures.[24] The submission to this inquiry from NSW Health included the following data:

- In 2020-21, 79 per cent of patients in EDs in New South Wales started clinical treatment within national benchmark times, compared to 71 per cent nationally. New South Wales EDs also had the shortest median wait time to treatment at 17 minutes, compared to 18 minutes nationally.
- In 2020-21, 68.97 per cent of all ED patients in New South Wales had a length of stay of four hours or less compared with 66.71 per cent nationally. New South Wales performance ranked, slightly behind Western Australia (70.77 per cent) and Queensland (69.11per cent).
- New South Wales was the only jurisdiction to achieve the ACEM target of 75 per cent for triage category 3 (urgent).

[24] See for example: Evidence, Dr Skinner, 5 October 2022, p 10; Evidence, Mr Waters, 5 October 2022, p 27; Evidence, Associate Professor Graham Reece, Intensive Care Specialist and Director, Intensive Care, Blacktown Hospital, 7 October 2022, p 27; Evidence, Ms Pearce, 7 October 2022, p 33.

- New South Wales EDs achieved the ACEM benchmark targets in all categories for emergency presentations seen on time except for triage category 2 (emergency). New South Wales's triage category 2 performance of 79 per cent was just under the benchmark of 80 per cent, however, was the highest performer nationally.
- In the transfer of care between ambulances and EDs, New South Wales is the better performer for the time taken for patients to be transferred off an ambulance stretcher to a hospital ED. In 2020-21, 84.8 per cent of New South Wales patients were transferred within 30 minutes, compared to 72.7 per cent in Victoria, 65.2 per cent in Queensland, 62.7per cent in Western Australia, 63.8 per cent in South Australia and 65.9 per cent in Tasmania. (The committee notes that all states and territories saw a decline in this measure over recent years.)[25]

1.34 Additionally, BHI conducted an ED Patient Survey in 2020-21 of 20,728 people who attended one of 77 of New South Wales's largest EDs for care from July 2020 to June 2021. It found:

- Almost all patients (89 per cent) said that overall, the care they received was 'very good' or 'good.'
- Almost eight in 10 patients (79 per cent) said that, while they were waiting to be treated, ED staff checked on their condition.
- Most patients (87 per cent) said they were 'always' treated with respect and dignity while in the hospital.
- More than eight in 10 patients (81 per cent) said ED health professionals 'always' explained things in a way they could understand.[26]

Committee comment

1.35 The committee understands that responsibility for health in Australia is divided between the Commonwealth and States/Territories. Problems with patient flow are caused at a variety of points across the whole health system where there is a lack of seamless integration – not just with ambulances, EDs and access block. This means that solutions must also be found across the whole system and involve all levels of government.

1.36 Patient flow is a problem across Australia and, indeed, many parts of the world. The committee heard that New South Wales performs better than other jurisdictions in Australia on many measures. It is important to recognise this to understand what parts of the health system work well.

1.37 It is equally important to recognise that behind data and statistics are patients and that the health system must address poor patient care where it occurs and respond to unacceptable standards wherever they exist.

1.38 The remainder of this report discusses ambulance ramping, ED overcrowding and access block beginning with the impact on EDs, patients and healthcare staff (chapter 2). This is followed by

25 Submission 35, NSW Health, p 10.

26 Submission 35, NSW Health, pp 13-14.

a high-level overview of the causes (chapter 3). The report concludes with a focus on how aspects of primary care contribute to the problem (chapter 4).

Chapter 2 Effects

This chapter reveals the negative impact poor patient flow is having on emergency departments (EDs), patients and healthcare staff. Evidence to this inquiry shows that EDs are changing how they operate in response to problems with patient flow. This can mean having to focus on priorities other than the clinical needs of patients.

Accordingly, this puts the health of patients in the New South Wales health system at risk. The impact on patients evident in the system include: compromised care; increased morbidity and, to a lesser extent, mortality; and a loss of dignity and privacy.

The chapter concludes by looking at how the current problems in the health system are affecting healthcare staff. Evidence shows that issues around patient flow are the largest cause of stress, poor morale and burnout for healthcare staff.

Effect on emergency departments

2.1 This section examines the impact of poor patient flow on how EDs function. The committee heard that delays waste time, resources and treatment opportunities. This happens as healthcare staff adapt their processes and procedures to accommodate for problems in the health system.

Detrimental impacts on emergency department function

2.2 Stakeholders referred to data showing how patient flow has worsened in New South Wales over recent years (similar to data the committee included in chapter 1 of this report) to explain how EDs are currently functioning. For example, the Australian Medical Association of New South Wales gave examples concerning worsening performances with patients who:

- transferred from the ambulance to the ED within 30 minutes
- had their treatment start within clinically recommended timeframes
- left the emergency department without, or before completing, treatment.[27]

2.3 The Health Services Union (NSW/ACT/Qld) surveyed its members working in public hospitals in August and September 2022, asking about problems with patient flow. The survey asked: 'How frequently does your facility's emergency department regularly experience delays in the assessment, treatment and admission of patients? How do these delays affect your ability to do your job?'.

2.4 Around 90 per cent of responders answered 'Usually' or 'Always' to the first question with responses to the second question including examples such as:

- triple-handling of patients for imaging
- moving patients to private hospitals under collaborative care to try and reduce the number of patients on waiting lists

[27] Submission 33, Australian Medical Association (NSW) Ltd, p 4.

- specimen triage in pathology labs determined by whoever is most persistent in chasing results.[28]

2.5 The survey also asked paramedic members the same questions. Again, around 90 per cent answered 'Usually' or 'Always' to the first question. Responses to the second question included examples such as:

- moving crews from regional towns into those areas with patient flow problems leaving a gap in ambulance cover for certain areas
- waiting with low acuity patients while colleagues requested assistance with more serious patients.[29]

2.6 This decline in the performance of the health system has created 'adverse system effects' in EDs. This refers to EDs changing their processes in response to the pressure of patient flow problems, rather than focusing solely on the clinical needs of patients. The Australian Salaried Medical Officers' Federation New South Wales (ASMOF) stated that overcrowded EDs 'do not function [and] can also lead to confusion over the responsibility for care for patients.'[30] Overcrowded EDs therefore create their own risks and, as Mr James Gray from the Australasian College for Emergency Medicine (ACEM) told the committee, managing that risk creates 'a lot of problems.'[31]

Effects on junior staff

2.7 The committee heard about current challenges training junior staff in New South Wales hospitals. Ms Kelly Falconer, a Registered Nurse for 25 years with 21 years' ED experience, said as a junior nurse she always had two senior staff guiding her. However, she cannot provide that level of guidance to her junior staff now because she is too busy looking after high-acuity patients. Ms Falconer said that many junior staff 'aren't even [trained in] advanced life support so they don't have the skills to give medications when required to because we should be there with them, teaching them at the time.'[32]

2.8 Dr James Tadros, an Emergency Medicine Staff Specialist, said students' professional experience in western Sydney hospitals can make it difficult for them to complete their exams. This is because some questions ask students what processes they should change when a hospital suddenly has to operate at above the 'normal' occupancy rate (around 85 per cent). However, as noted in chapter 3 of this report, most hospitals currently operate permanently at 100 per cent occupancy. Dr Tadros told the committee: 'There have been situations where people have been confused by the question because the question alludes to a disaster and they're expected to identify that but that for them is what they're doing every single day.'[33]

28 Submission 34, Health Services Union (NSW/ACT/Qld), pp 5-6.

29 Submission 34, Health Services Union (NSW/ACT/Qld), pp 6-7.

30 Submission 29, ASMOF NSW - the Doctors' Union, pp 2; 5.

31 Evidence, Mr James Gray, Manager – Policy and Advocacy, Australasian College for Emergency Medicine, 5 October 2022, p 4.

32 Evidence, Ms Kelly Falconer, Registered Nurse and member, NSW Nurses and Midwives' Association, 5 October 2022, p 44.

33 Evidence, Dr James Tadros, Emergency Medicine Staff Specialist, 5 October 2022, p 34.

2.9 The Australasian College of Paramedicine discussed how time pressures can make staff focus on 'symptom treatment rather than core issue treatment.'[34] Another example was provided by the South Western Sydney Local Health District Medical Staff Council Chairs in its submission when it mentioned patients being moved out of resuscitation bays before being fully stabilised.[35]

Effects on regional hospitals

2.10 The impacts of poor patient flow on EDs are particularly acute outside of metropolitan areas (Newcastle, Sydney and Wollongong). Mr Scott Beaton, a Station Officer in Central West New South Wales and Vice President of the Australian Paramedics Association (New South Wales), told the committee that, for example, two hours of ramping for an ambulance in regional New South Wales can mean a town will have no available ambulance for as long as six or seven hours.[36]

2.11 Dr Clare Skinner, President of ACEM, explained that in small hospitals all staff are needed to provide critical care to patients. The team becomes free if that patient can be transferred to a major hospital, however:

> … if that person waits there for hours, that entire team is then providing ongoing care in sort of a pseudo-ICU environment within the emergency department. That renders the them not able to provide timely care in a proactive way to the other patients who are waiting at that emergency department. So this is a significant issue for smaller emergency departments.[37]

Effect on patients

2.12 The overriding concern of stakeholders and committee members throughout this inquiry was the quality of care provided to patients in the New South Wales health system. The committee heard that EDs changing their processes and procedures due to poor patient flow can lead to:

- compromised care
- increased morbidity and, to a lesser extent, mortality
- a loss of dignity and privacy.

Adverse impacts of access block

2.13 ACEM provided the committee with examples of adverse patient outcomes, including:

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34 Submission 28, Australasian College of Paramedicine, p 4.

35 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 4.

36 Evidence, Mr Scott Beaton, Station Officer - Central West and Vice President, Australian Paramedics Association (NSW), 5 October 2022, p 15.

37 Evidence, Dr Clare Skinner, President, Australasian College for Emergency Medicine, 5 October 2022, p 8.

- delayed access to definitive assessment and care because of slowed ambulance response times
- decreased privacy for patients and reduced patient dignity
- increased workplace health and safety complications arising from having to use inappropriate spaces to treat patients
- increased harm occurring in the waiting room due to long waits and insufficient staffing to identify deteriorating patients.[38]

2.14 In its submission to this inquiry, the Australasian College of Paramedicine identified the following impacts on patients:

- delays in assessment and treatment
- increased risk of exposure to error
- increased length of stay in the hospital
- worse health outcomes
- increased inpatient mortality.[39]

Adverse impacts when ambulances cannot offload patients

2.15 Delays in transfer of care at hospitals when ambulances cannot offload patients mean they then cannot respond to further emergency calls. According to Mr Beaton, this 'seriously compromise[s] the ability of ambulance services to perform their primary function of responding to life-threatening emergencies in the community, with flow on effects for paramedics and patients.'[40]

2.16 The way in which hospitals respond to the effects of ambulance ramping on the wider health system also puts patients at risk. Ms Shaye Candish, General Secretary, NSW Nurses and Midwives' Association, told the committee that some hospitals have introduced Key Performance Indicators (KPIs) targeting ambulance offload times. She said that this emphasis on offload time is one reason why patients arriving by ambulance are prioritised over self-presenting patients, 'which undermines the process of clinical triage whereby access to treatment is based on acuity or need.'[41]

2.17 Dr James Tadros and Dr Pramod Chandru, Emergency Medicine Staff Specialists, cautioned against introducing 'punitive' KPIs that can make the problem worse:

> Stop focusing on isolated metrics such as offload times and give departments the resources and ability to review factors that hamper flow such as system inefficiencies.

38 Submission 16, Australasian College for Emergency Medicine, pp 2-3.

39 Submission 28, Australasian College of Paramedicine, pp 2-6.

40 Submission 23, Taylor Fry Pty Ltd, p 4.

41 Evidence, Ms Shaye Candish, General Secretary, NSW Nurses and Midwives' Association, 5 October 2022, p 41.

> Such punitive and non-reflective KPIs only serve to exacerbate the problem as staff become pre-occupied with these rather than improving the system as a whole.[42]

2.18 The next impact of poor patient flow is care being compromised for patients who are not being treated in an appropriate place.[43] The Australian Medical Association of New South Wales expressed concern that patient care may be 'inappropriate, inadequate or absent altogether.'[44]

2.19 The committee received evidence that Patient Flow Nurse Unit Managers in hospital wards are being pressured to take people from the ED to clear ambulance ramping, even if there is no appropriate place to take the patient.[45] The committee also heard of EDs where anywhere from one-quarter to one-half of patients are being treated in 'inappropriate treatment spaces.'[46]

2.20 In his submission to this inquiry, Dr Kendall Bein wrote: 'It is possible to medically manage a patient still on an ambulance trolley and certainly to provide urgent care, but not with the care, safety, dignity or quality that the patient should expect.'[47]

2.21 It is important to note that emergency medicine staff are trained to provide acute episodic care, not ongoing care. They do not have the skill set to provide care that lasts more than several hours.[48] Speaking specifically about paramedics, Mr David Waters from the Council of Ambulance Authorities said: 'Caring for a patient on a stretcher requires them to consider things like nutrition, toileting, pressure area care—many, many nursing-related aspects that they wouldn't normally have to consider and they're having to adapt to.'[49]

2.22 In its submission, the Health Services Union (NSW/ACT/Qld) included evidence from an intensive care paramedic describing situations where low-acuity patients 'are left completely unattended for hours such that what would have been a minor event becomes a significant one'.[50]

2.23 The South Western Sydney Local Health District Medical Staff Council Chairs referred to the 'double-whammy' of patients suffering because their care has been delayed as well as those patients then contributing to poor patient flow.[51] Ms Candish elaborated that nurses working in overcrowded EDs will only be able to learn a limited medical history of their patients before beginning treatment. Added to this, when nurses are given too many patients to look after 'their capacity to monitor and to intervene when something goes wrong is also diminished.'[52]

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42 Answers to questions on notice, Dr James Tadros and Dr Pramod Chandru, Emergency Medicine Staff Specialists, 4 November 2022, p 2.

43 Submission 26, Professor James Mallows, p 9.

44 Submission 33, Australian Medical Association (NSW) Ltd, p 8.

45 Submission 31, New South Wales Nurses and Midwives' Association, p 8.

46 Evidence, Dr Pramod Chandru, Emergency Medicine Staff Specialist, 5 October 2022, p 37.

47 Submission 20, Dr Kendall Bein, p 5.

48 Evidence, Dr Skinner, 5 October 2022, p 4.

49 Evidence, Mr David Waters, Chief Executive, The Council of Ambulance Authorities Inc, 5 October 2022, p 28.

50 Submission 34, Health Services Union (NSW/ACT/Qld), p 11.

51 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 5.

52 Evidence, Ms Candish, 5 October 2022, p 45.

Adverse impacts on mental health patients

2.24 The Royal Australian and New Zealand College of Psychiatrists said that mental patients are suffering from delayed or inadequate emergency care, including leaving EDs without being treated.[53] The committee heard from the NSW Nurses and Midwives Association that this can put mental health patients, other patients in the ED and staff at risk.[54] Negative outcomes are exacerbated when patients return to the community without access to appropriate therapeutic follow-up care.[55]

2.25 In its submission, the College collated data from the Australian Institute of Health and Welfare showing that in New South Wales in 2020–2021:

- 74.1 per cent of mental health-related presentations were seen on time, the best performance of any State or Territory
- around 3 per cent of people presenting at EDs for mental health reasons were in the categories 'Did not wait to be attended by a health care professional' or 'Left at own risk.'[56]

2.26 The Australian Medical Association of New South Wales referred to recent data showing that although there were fewer mental health episodes of care recorded in the most recent quarter, mental health average length of stays increased by four days from 18.7 days in April–June 2019 to 22.7 days in April–June 2022. Further, the total bed days taken up by mental health patients over the same period increased by 10 per cent to just under 200,000 days.[57]

Impacts on patients of long wait times

2.27 At a public hearing, Dr Pramod Chandru described how low-acuity patients can become in need of urgent care when treatment is delayed. He gave the example of a category three patient, who should be reviewed within 30 minutes, waiting for over three hours, meaning they may become a more urgent category two patient. Dr Chandru discussed how patients who have 'transcended their category' deteriorate because of delays in the ED, adding: 'Now it becomes very difficult to know if I should go see the chest pain within 10 minutes or if that patient who has been a category three, who has been deemed to be clinically urgent enough to be reviewed in 30 minutes is, in theory, a lower number now.'[58]

2.28 At the same hearing, Dr Tadros spoke about his experiences seeing patients decline because of problems with patient flow. He told the committee:

> There are situations that are very frustrating, where you have made the effort to see a patient in a corridor, with absolutely no privacy, in a loud situation, sitting on a plastic chair. You have identified their issues. You have made a plan for treatment, but you

53 Submission 14, Royal Australian and New Zealand College of Psychiatrists, p 6.

54 Submission 31, New South Wales Nurses and Midwives' Association, p 18.

55 Submission 31, New South Wales Nurses and Midwives' Association, p 25.

56 Australian Institute of Health and Welfare, *Mental health services in Australia, Emergency department mental health services*, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services, accessed 1 November 2022.

57 Bureau of Health Information, Healthcare Quarterly April – June 2022.

58 Evidence, Dr Chandru, 5 October 2022, p 35.

> cannot initiate that treatment due to a lack of treatment space. You can watch them deteriorate in front of your eyes just because you don't have any access to treatment for them.[59]

2.29 The committee received many first-hand experiences of the negative effects of poor patient flow on patients. Several are included below:

> I am aware of patients being transported to imaging such as x-ray or ultrasound by ambulance staff, as the imaging is deemed "urgent" but because there is no bed for the patient, they have not been admitted to the care of the ED, so remain under the care of the paramedics.[60]

> Our daughter was placed on her ambulance trolley, outside of the hospital due to there being no available beds in emergency, this is where she regained almost all awareness to her surroundings. To her left, was an elderly patient also on a trolley, whom our daughter thought to be deceased, to her left, another elderly patient, again who looked deceased. So there's our 13 year old child, lying, after coming to from having a full medical episode, scared, without her dad or mum, between two people she thought were dead.[61]

> I am writing with a heavy heart sitting in a chair in a makeshift room in the emergency department at the John Hunter Hospital … The nurses and doctors at the John Hunter are run off their feet with ambulances banked up, elderly patients sitting in beds or wheelchairs with no beds for admission into the hospital, people with broken bones, bleeding …[62]

> This is a submission for our health crisis. As a young mum I would like to know if anything were to happen my child would be taken care of in efficient time, instead of waiting long periods for an ambulance and then again hours in ED.[63]

> Ambulances are ramped at our department because most days we have up to 30 admitted patients waiting 24–30 hours for a bed on the ward. These are largely medical patients, mostly elderly people. Surgical patients are prioritised and streamed to the wards. We only have 22 acute beds! Patients are sleeping in recliner chairs in short stay areas too. We recently had an elderly lady with dementia awaiting a medical bed for over 120hrs. Occasionally children wait in our mixed adult/kids ED overnight, and this never used to happen.[64]

2.30 The Secretary of NSW Health, Ms Susan Pearce, reinforced with the committee that EDs must always prioritise those patients most in need of care. She said: 'Sometimes that means that people who are less unwell or in lower triage categories wait longer. That is the nature of emergency. And it's the nature of how our emergency departments will always operate.'[65]

59 Evidence, Dr Tadros, 5 October 2022, p 35.

60 Submission 3, Name Suppressed, p 1.

61 Submission 4, Name Suppressed, p 1.

62 Submission 5, Ms Bridgit Akmacic, p 1.

63 Submission 6, Ms Alex Powell, p 1.

64 Submission 13, Name Suppressed, p 1.

65 Evidence, Ms Susan Pearce, Secretary, NSW Health, 7 October 2022, pp 38-39.

Is there an increase in patient mortality?

2.31 The committee questioned stakeholders on whether there is increased mortality caused by poor patient flow. Recent discussions on increased mortality have been particularly influenced by a study in the *Medical Journal of Australia*. The paper reported findings that the risks of death and ambulance re-attendance with chest pain within 30 days of initial ED presentation were higher when the offload time exceeded 17 minutes.[66]

2.32 Dr Clare Skinner told the committee that 'there's a 10 per cent increase in preventable mortality when more than 10 per cent of patients in the emergency department have waited too long—over eight hours—to access an inpatient bed after their emergency department care is completed.'[67]

2.33 The committee did not receive evidence that problems with patient flow are causing a notable increase in deaths in New South Wales. For example, Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, said: 'I have to say that [deaths] do occur, but they're not very frequent.'[68]

2.34 The committee heard that this is due to the skill of healthcare staff and their awareness of the needs of people in their care. Dr Ung expanded on how 'near misses' – effectively saving patients who have deteriorated from dying – are detrimental both to patients' health and staff wellbeing. He told the committee:

> The patients who get salvaged—you know, they've been waiting for a long time then they finally get picked up and there's a quick flurry of activity. Their lives are saved but the staff are under constant stress trying to patrol their department, trying to pick out these patients from the wait rooms because they're not in a bed initially to be assessed appropriately.[69]

Effect on healthcare staff

2.35 Along with concern for patients, the committee focused on how current problems in the health system are affecting healthcare staff. This includes: ED specialists; ED nurses and Registered Nurses; paramedics; pharmacists; and others including orderlies and cleaners. The committee heard from multiple stakeholders that issues around patient flow are the largest cause of stress, poor morale and burnout for healthcare staff.[70]

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66 Cate Swannell, The Medical Journal of Australia, *Ambulance ramping associated with 30-day risk of death* (4 July 2022), https://www.mja.com.au/journal/2022/ambulance-ramping-associated-30-day-risk-death, accessed 1 November 2022.

67 Evidence, Dr Skinner, 5 October 2022, p 2.

68 Evidence, Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, 5 October 2022, p 35.

69 Evidence, Dr Ung, 5 October 2022, p 35.

70 For example see: Evidence, Dr Skinner, 5 October 2022, p 2; Evidence, Mr Beaton, 5 October 2022, p 15; Evidence, Dr Tadros, 5 October 2022, p 34; Evidence, Dr Ung, 5 October 2022, p 36; Evidence, Dr Chandru, 5 October 2022, p 37; Evidence, Mr Jerry Yik, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia, 7 October 2022, p 12; Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 7; Submission 28,

First-hand accounts of impacts on healthcare staff

2.36 In 2021, the Australian Medical Association of New South Wales conducted a 'Senior Doctor Pulse Check Survey' in public hospitals. A total of 80 per cent of respondents reported experiencing workplace stress, with the majority citing a lack of resources and excessive workloads as the source of that stress.[71]

2.37 According to ACEM, the impacts on staff of problems with patient flow include:

- increased stress and interpersonal conflict between patients, paramedics, executives and ED staff
- adverse publicity leading to poor staff morale and negative public perceptions of the health system
- decreased staff wellbeing and job satisfaction leading to staff losses, particularly among specialists and senior nurses.[72]

2.38 The committee received evidence from paramedics that they are experiencing:

- missed meal breaks
- forced overtime
- psychological stress
- feelings of frustration and responsibility for the potential harm to patients waiting for care.[73]

2.39 In its submission, the Health Services Union (NSW/ACT/Qld) included evidence from paramedic in Western Sydney who spoke about the physical pain caused by having to stand for several hours with their patients while waiting to offload them. The paramedic added: The process of waiting is also mentally draining, particularly if you are managing a complex patient who still requires active interventions whilst waiting for hours … Often times people will just call in sick to try and recover from the day previous.'[74]

2.40 The Australian Paramedics Association in its submission raised the necessity for hospitals that experience bed block to 'provide paramedics with a mobile work trailer for paramedics to use to write clinical notes, drink, and eat out of the elements. Paramedics cannot continue to huddle in sheets, work on trestle tables next to PPE bins, or feel on the brink of fainting due to heat stress.'[75]

Australasian College of Paramedicine, p 6; Submission 34, Health Services Union (NSW/ACT/Qld), p 10.

71 Submission 33, Australian Medical Association (NSW) Ltd, p 10.

72 Submission 16, Australasian College for Emergency Medicine, p 3.

73 Submission 19, Australian Paramedics Association (NSW), pp 3-5; Submission 28, Australasian College of Paramedicine, p 6.

74 Submission 34, Health Services Union (NSW/ACT/Qld), p 10.

75 Submission 19, Australian Paramedics Association (NSW), p 17.

2.41 At a public hearing, Ms Suzanne Melchior, a Senior Registered Nurse from the Northern Rivers, described the effect of poor patient flow on healthcare staff. She told the committee:

> The effect on the frontline workers when they have all beds full, several ambulance stretchers lined up, full waiting rooms with some people also needing a bed space to begin treatment is, of course, that they are stressed. We're having to blinker ourselves to the presentations on those worst shifts, which we know we can help with but having to attend the highest clinical need only. So begins the process of moral injury.[76]

2.42 As Ms Melchior's comments show, a large driver of stress for healthcare staff experiencing problems with patient flow is the worry that they are not providing the best possible care to their patients. As with the impact on patients, the committee received many first-hand experiences of the negative effects of poor patient flow on healthcare staff. Several are included below, with a particular emphasis on the quality of care provided to patients:

> It's like working with a conveyor belt full of things you can't get to fast enough, but what's on the conveyor belt is human distress and suffering. It causes enormous moral injury to be in a position where you are trained to provide care and you are not able to provide it in a timely way …[77]

> Sleepless nights contemplating decisions made in the heat of the moment is a plague on the profession, and as these decisions are made by less confident and less competent staff, the burden they lay on the decision maker is greater and greater. This war of attrition with one's own nerves is one of the foundational causes for burnout in the profession … Being a pragmatist at my core I walk into my shifts fully aware that the medicine I will practice and the care I will provide will be below the standards that I set for myself. We are taught never to forget these standards, and so to face them every day as a failure can be exhausting.[78]

> … it's the impact on our colleagues and our doctors, nurses and paramedics who are trying to look after these patients and who, because of the systems that we're working within, are inhibited from being able to provide best care. That's why we come into this profession.[79]

> Inevitably, it means that you're taking on more patients than you can care for. You're rationing the care that you're offering. If I'm a nurse who has eight patients and I'm taking on two more, I can't just give more care to two more people. I don't have any more hands. So I'm now deciding who gets prioritised …[80]

2.43 Dr Kendall Bein argued that healthcare staff can feel unable to fix the problem. He said this 'worsens the impact it has and breeds a sense of powerlessness, and that those with the power to influence it do not care for the wellness of you, your patients or your colleagues.'[81]

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76 Evidence, Ms Suzanne Melchior, Senior Registered Nurse, Northern Rivers NSW, 5 October 2022, p 50.

77 Evidence, Dr Skinner, 5 October 2022, p 4.

78 Submission 21, Dr Pramod Chandru and Dr James Tadros, p 4.

79 Evidence, Ms Michelle Murphy, Advocacy and Government Relations Lead, Australasian College of Paramedicine, 5 October 2022, p 16.

80 Evidence, Ms Candish, 5 October 2022, p 45.

81 Submission 20, Dr Kendall Bein, p 9.

Healthcare staff leaving the sector

2.44 Stress and burnout are seeing healthcare staff decrease their work hours[82] or leave the sector altogether. Dr Setthy Ung said that the increased stress of the past several years has 'accelerated' burnout of ED doctors to the point where they are now leaving the profession in their mid-40s, much earlier than in the past. He said: 'It's really, really tragic and, more importantly, we can't backfill them, either. As soon as they burn out, there is a very small pool of junior medical staff who can then be trained up to become a senior medical officer.'[83]

2.45 Ms Kelly Falconer, a Registered Nurse for 25 years with 21 years' ED experience, said that nurses are 'leaving the profession due to many reasons, but mainly because of increasingly unsafe workloads, unsafe working environments with increased aggression and violence, and unhealthy work-life balance due to constant demand of extra and overtime shifts.'[84]

2.46 The Royal Australian and New Zealand College of Psychiatrists told the committee that psychiatry workforce shortages are mostly found in:

- settings such as inpatient units and EDs
- sub-specialties such as addiction psychiatry and child and adolescent psychiatry.[85]

2.47 In its submission, the college mentioned Nepean Hospital, which has 'nine psychiatry consultant positions vacant at present and another 10 short-term (3 month) Visiting Medical Officer (VMO) contracts that are regularly renewed at the last minute because of workforce shortages and problems attracting specialists to newly created roles.'[86]

2.48 When questioned whether there was a 'disconnect' between the evidence from frontline staff about the extent of the problems with the health system stemming from poor patient flow, and the view presented by NSW Health, Ms Pearce responded:

> … I don't believe there's a disconnect between NSW Health and the system. I've been very open and direct about the fact that our staff have been under enormous challenge. I've said that today. I've said it publicly …
>
> We are not disconnected from our system. We know that there are days which are incredibly difficult. I do not support the comment, from my perspective looking at the system, that every day is a disaster.[87]

Current measures being undertaken by NSW Health

2.49 NSW Health described the staff recruitment and wellbeing initiatives being implemented to address ambulance ramping, access block and emergency department delays.

82 Submission 31, New South Wales Nurses and Midwives' Association, p 3.

83 Evidence, Dr Ung, 5 October 2022, p 36.

84 Evidence, Ms Falconer, 5 October 2022, p 42.

85 Submission 14, Royal Australian and New Zealand College of Psychiatrists, p 3.

86 Submission 14, Royal Australian and New Zealand College of Psychiatrists, p 3.

87 Evidence, Ms Susan Pearce, Secretary, NSW Health, 7 October 2022, p 41.

Staff recruitment

2.50 The committee heard that in June 2022, the NSW Government invested $4.5 billion in the health sector workforce to recruit 10,148 full-time equivalent staff to hospitals and health services. This includes $1.8 billion to enable NSW Ambulance to recruit 2,128 staff.[88]

2.51 Ms Susan Pearce told the committee that around 3,700 newly graduated nurses and midwives will begin working in 2023. Ms Pearce acknowledged that recruiting registered nurses is a challenge 'being experienced not just in New South Wales but it's a worldwide issue with health staff.'[89]

2.52 Regarding senior staff, Ms Pearce said that recruitment is difficult because of a shortage of experienced healthcare staff in the market. As such, NSW Health expressed its commitment to supporting the career development of junior staff. Ms Pearce said:

> The issue is that sometimes we keep trying to recruit more experienced staff and they're just not there. That's not a failing; it's just a fact. We have a lot of really excellent less experienced staff that we recruit every year. Our job is to then support them into the workplace, and so it's really important that we look at it in that way.[90]

2.53 Ms Pearce gave the example of a 'significant increase in clinical nurse educators' of 50 per cent over the past 10 years 'to support less experienced staff.'[91]

Staff wellbeing

2.54 NSW Health told the committee it has been funded to continue existing wellbeing programs and establish new ones. In late 2021, a Workforce Wellbeing Collaborative was also established to prioritise and promote wellbeing for all NSW Health staff.[92]

2.55 An additional workforce resilience package is also being rolled out over 2022-23 to address the ongoing impacts of COVID-19 on staff. The committee heard that Local Health Districts, SHNs and NSW Ambulance 'can use this funding to build capacity through additional workforce supply to backfill for furlough and leave, as well as offsetting attrition and other staff absence due to fatigue.'[93]

2.56 Ms Pearce explained that addressing fatigue through facilitating overdue leave entitlements is a large component of NSW Health's approach to improving staff wellbeing. She told the committee:

> I don't think we can underestimate the impact that not having proper leave has had on staff in health systems in all jurisdictions and on all of us who have worked now for a

88 Submission 35, NSW Health, p 31.
89 Evidence, Ms Pearce, 7 October 2022, p 35.
90 Evidence, Ms Pearce, 7 October 2022, p 37.
91 Evidence, Ms Pearce, 7 October 2022, pp 37-38.
92 Submission 35, NSW Health, p 32.
93 Submission 35, NSW Health, p 32.

very long time with very limited periods of leave. It's certainly not something that we want to see continue, so it's important that we arrest that trend very quickly.[94]

Committee comment

2.57 The committee is concerned that problems with patient flow are causing adverse system effects across New South Wales. Examples that we were made aware of include:

- staff being unable to follow correct processes and procedures, including providing treatment within clinically recommended timeframes
- different parts of the system acting in ways that put pressure on other parts of the system – for example, offloading patients from an ambulance when an ED is already at full or overflowing capacity.

2.58 As a result, patients can suffer poorer outcomes as their care is compromised. The evidence presented to this inquiry includes examples of patients' health deteriorating because of delays in being treated or treatment being delivered in inappropriate places. The committee also heard of patients being discharged too early or deciding to leave before being treated feeling they have waited too long. This can lead to them re-presenting in a more acute state, ultimately costing the health system more in the long run.

2.59 Healthcare staff spoke of declining morale and burnout because of missing meal breaks, excessive overtime and being unable to take leave. Particularly concerning was the personal stress of believing they have failed to provide appropriate care to their patients, the very reason they became healthcare staff. The committee notes that if this is the case, it is because of forces outside the control of staff in the New South Wales health system.

2.60 The committee accepts that NSW Health is aware of the problems with patient flow in this state and is making some effort to improve the situation. However, the committee is concerned that NSW Health's focus on macro, state-level data, while necessary and important, risks it not fully appreciating the specific challenges some hospitals face on a daily basis. The sense of a 'disconnect' between NSW Health and healthcare staff raised in this inquiry echoes evidence on micro-level problems raised in this committee's previous inquiries into health services in south-west Sydney[95] and rural, regional and remote New South Wales.[96]

2.61 The committee calls on NSW Health to continue to support its staff and prioritise staff wellbeing through initiatives such as reducing leave balances. It is vital to recruit sufficient numbers of new staff, including senior staff. Where experienced healthcare staff cannot be recruited, junior staff must be supported to ensure they have long and fulfilling careers in the health workforce. This will then improve the quality of care all patients receive.

2.62 It is clear that many of the problems discussed in this report, which are significantly affecting patients and healthcare staff, are systemic issues. The next two chapters identify the most

94 Evidence, Ms Pearce, 7 October 2022, p 38.

95 Portfolio Committee No. 2 – Health, NSW Legislative Council, *Current and future provision of health services in the South-West Sydney Growth Region* (2020).

96 Portfolio Committee No. 2, NSW Legislative Council, *Health outcomes and access to health and hospital services in rural, regional and remote New South Wales* (2022).

prominent issues raised in this inquiry and include recommendations that address the root causes of poor patient flow in New South Wales.

2.63 The committee is concerned that paramedics are required to wait for extensive periods outside emergency departments without appropriate facilities. It is vital that paramedics are able to properly rest and shelter from adverse weather at hospitals experiencing bed block.

Recommendation 1

That NSW Health ensure that every hospital that experiences bed block provides dedicated paramedic work zones out of the elements.

Chapter 3 Causes

This chapter provides a high-level overview of the causes of ambulance ramping, emergency department (ED) overcrowding and access block as presented to the committee in evidence to this inquiry. It does this through describing stresses across the whole health system in New South Wales, beginning with the impacts of the COVID-19 pandemic and recent natural disasters; the impact of fragmented funding; and the influence of demographic and socioeconomic factors.

Structural problems with the health system are also hampering patient flow, including:

- the relationship between community-based care and ED presentations and hospital discharge
- bed numbers
- hospital occupancy rates
- hospitals operating for fewer hours than EDs
- insufficient integration of the different parts of the health system.

The chapter concludes with a discussion on how staffing in EDs and hospitals affects ambulance ramping and access block. This includes both the number of staff and their seniority and expertise.

Stresses on the health system

3.1 The New South Wales health system is under stress from various factors: natural disasters and the COVID-19 pandemic, fragmented state and federal funding and demographic pressures including an ageing population as well as socioeconomic factors.

Natural disasters and COVID-19

3.2 Recent natural disasters and the COVID-19 pandemic continue to place great stress on the New South Wales health system.

3.3 NSW Health told the committee that the Black Summer bushfires of 2019-20 and the floods of 2021 and 2022 have had a 'compounding effect' on the New South Wales health system. Across the state, EDs and acute care facilities remained open, with support provided to affected facilities. However, 'the continuous and widespread nature of these events over the past few years has placed pressure on the ability of the system to operate as it would normally.'[97]

3.4 COVID-19 also affected how the health system performed, in terms of increased presentations (after an initial drop-off, as discussed in chapter 1), presentation type (often complex respiratory problems) and staffing numbers (discussed below). EDs in New South Wales saw patients presenting with acute respiratory infections, peaking in mid-January 2022, with up to 1,400 presentations each week during the height of the initial Omicron outbreak. According to NSW Health, these rates have not returned to the low inter-wave levels seen in 2021.[98] An early

97 Submission 35, NSW Health, p 16.

98 Submission 35, NSW Health, p 23.

influenza season, which began at the end of April 2022, and an increase in presentations for bronchiolitis in infants and young children were extra challenges.[99]

3.5 The average length of stay in hospital for admitted patients increased from 5.4 days at the end of 2017 to 6.4 days around the middle of 2021, reducing the number of beds available to admit new patients. The longer lengths of stay partly reflected the ongoing cumulative effect of patients with more severe morbidity.[100]

3.6 NSW Health advised that they responded by being 'agile in the review, revision, and augmentation of different models of care … across all areas of the system … EDs established "hot" zones to deal with increases in cases with COVID-19 or those with the potential to have acquired the disease.'[101]

3.7 As well, an Adaptive Model for Adult Intensive Care Units (ICUs) was developed to guide intensive care staff throughout the pandemic. This included training in alternative models of care to respond to surge periods or ICU staff shortages. Finally, an ICU Patient Flow Coordinator service was developed to improve patient flow during COVID-19 outbreaks.[102]

3.8 Ms Susan Pearce, the Secretary of NSW Health, stressed that the health system will take time to recover from the pandemic. She told the committee that 'the impact of it is not forgotten and it's going to take us some time to get through that, and that's what we're aiming to do.'[103]

Fragmented funding

3.9 Stakeholders in this inquiry identified the 'fragmented nature' of public hospital funding in Australia as a problem.

3.10 As noted in chapter 1 of this report, the Commonwealth and the States/Territories share responsibility for funding public hospitals. The Commonwealth contributes 45 per cent of the cost of public hospital services each year, while the states and territories fund the remaining 55 per cent. The committee is aware that the Commonwealth agreed to a temporary 50/50 split at the beginning of the COVID-19 pandemic. This will end on 31 December 2022 at which point the 45/55 split will be restored.

3.11 In its submission, the Australian Medical Association of New South Wales also pointed out that the amount of public hospital funding provided by the Commonwealth is adjusted retrospectively based on services delivered in the previous year. However, this is limited by a cap on annual funding growth of 6.5 per cent. This means that if the cost of services grows by more than 6.5 per cent, this extra funding must be met by the states and territories.

3.12 According to the Australian Medical Association of New South Wales, this cost-shifting means that states and territories may limit what they deliver 'to keep within the Commonwealth funding

99 Submission 35, NSW Health, p 16.
100 Submission 35, NSW Health, pp 24-25
101 Submission 35, NSW Health, p 16.
102 Submission 35, NSW Health, p 16.
103 Evidence, Ms Susan Pearce, Secretary, NSW Health, 7 October 2022, p 43.

cap (which comes at the expense of meeting hospital demand for services) or find more State revenue to pay for increased hospital activity.'[104]

3.13 At a public hearing, the President of the Australian Medical Association of New South Wales, Dr Michael Bonning, added that this model is a 'disincentive for States to actively go after providing more care because, beyond a 6.5 per cent increase, they will be the ones paying for all of the care themselves rather than in a measured or a shared model.'[105]

3.14 Other stakeholders told the committee that the way in which Medicare funding operates, funding a limited range of health professionals such as GPs and nurse practitioners, restricts the type of services that communities can receive.

3.15 Ms Michelle Murphy from the Australian College of Paramedicine stated:

> … if you can't get a GP or a nurse practitioner in the community, then you can't have any health professional. You might have extended care paramedics and physios and pharmacists who want to come and work in the community but, because of the funding model, they can't come. The community will go without any kind of health care because our model says that it has to be a GP or a nurse practitioner because it has to be under the Medicare scheme.[106]

3.16 As an example of what was presented to be a discrepancy, Associate Professor Ray Bange OAM explained to the committee that the Commonwealth does not recognise paramedics for reimbursement via a Medicare item. He said that when a service provides a paramedic 'then the doctor or the person with the Medicare provider number has to see the patient as well in order to bill and that means there's already a barrier to the employment or deployment of paramedics within clinic situations.'[107]

3.17 The number of practising hospital pharmacists was another issue raised by stakeholders. The example of pharmacists shows the fragmented nature of funding: community pharmacies are funded by the Commonwealth, but hospital pharmacists are funded by hospitals/Local Health Districts. The following case study illustrates how patient flow may be improved by making better use of hospital pharmacists.

104 Submission 33, Australian Medical Association (NSW) Ltd, pp 2-3.

105 Evidence, Dr Michael Bonning, President, Australian Medical Association NSW, 7 October 2022, p 3.

106 Evidence, Ms Michelle Murphy, Advocacy and Government Relations Lead, Australasian College of Paramedicine, 5 October 2022, p 23.

107 Evidence, Associate Professor Ray Bange, OAM, Private individual, 5 October 2022, p 29.

Case study: Hospital pharmacists

Discussing emergency medicine pharmacists, Mr Jerry Yik from the Society of Hospital Pharmacists of Australia informed the committee that there are 400,000 medication-related presentations to EDs across Australia, many due to medication shortages. He said:

> We see this all the time, actually—patients that have run out of their insulin. What do you do when you run out of insulin and there is a shortage and the pharmacy is not open? Well, you go to the ED. We know patients go to the ED when they run out of their methadone, when they run out of their pain medicines.[108]

Dr Jonathan Penm from the Society of Hospital Pharmacists of Australia told the committee that a shortage of pharmacists in New South Wales hospitals is a major contributing factor to problems with patient flow. He said that pharmacists can assist patient flow by:

- taking a timely and accurate medication history as part of the admissions process
- identifying medication-related presentations and resolving these issues in the ED, preventing the need for the patient to be admitted
- supplying discharge medicines for discharges from the ED.[109]

Dr Penm said that more pharmacists are needed in public hospitals in New South Wales, especially as patients' discharge prescriptions are becoming increasingly complex, adding: 'Furthermore, our members tell us that patients are often kept in the hospital unnecessarily over the weekend as inpatients, as there are no pharmacy services on the weekend to provide medications.'[110]

The Society of Hospital Pharmacists of Australia argued that New South Wales should become a signatory of the Pharmaceutical Reform Agreements (PRA).[111]

The Australian Government Department of Health introduced bilateral PRAs from 2001 to support the implementation of the Pharmaceutical Benefits Scheme in hospitals, and these agreements are now in place with all states and territories except New South Wales and the Australian Capital Territory. The PRAs permit approved public hospitals to prescribe and dispense PBS-subsidised medicines, chemotherapy drugs and highly specialised drugs to day-admitted patients, outpatients and patients upon discharge.

The society informed the committee that patients being discharged from public hospitals in New South Wales are currently supplied 3-7 days' worth of discharge medicines. This contrasts with other jurisdictions who supply a months' worth of discharge medicines.[112]

The society recommended implementing Partnered Pharmacist Medication Charting (PPMC), a process whereby pharmacists chart a patient's medication history instead of junior doctors, as is often case at the moment.[113] The Society's Mr Jerry Yik said that evidence from States with PPMC in place,

108 Evidence, Mr Jerry Yik, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia, 7 October 2022, p 12.

109 Evidence, Dr Jonathan Penm, Chair, NSW Branch committee, The Society of Hospital Pharmacists of Australia, 7 October 2022, p 8.

110 Evidence, Dr Penm, 7 October 2022, p 8.

111 Submission 15, The Society of Hospital Pharmacists of Australia (SHPA), p 1.

112 Submission 15, The Society of Hospital Pharmacists of Australia (SHPA), p 2.

113 Submission 15, The Society of Hospital Pharmacists of Australia (SHPA), p 1.

such as Victoria and Western Australia, shows that this speeds up the administration process, reduces errors and patients' length of stay, and lightens the workload for other staff.[114]

Mr Yik said that 'partnered pharmacist medication charting in hospitals is the first iteration of pharmacists prescribing in the Australian landscape.'[115] Dr Liz Swinburn informed the committee that the Royal North Shore Hospital is currently engaged in a trial 'where a hospital pharmacist is doing the prescribing, and it's fantastic.'[116]

Dr Tony Sara, President, Australian Salaried Medical Officers' Federation, welcomed a discussion on expanding the roles of hospital pharmacists but warned against changes that would allow community pharmacies to prescribe medication.[117]

At the time of writing this report the NSW Government announced a 12-month trial allowing community pharmacists to prescribe a wider range of vaccines and treatments.[118]

Demographic and socioeconomic factors

3.18 In this inquiry, evidence also focused on the impact on the health system of an ageing population and socioeconomic factors.

3.19 Regarding the ageing population, the committee learnt that it is not simply that people are living longer that creates issues for the health system. The important point to note is that people are living longer with diseases and co-morbidities that require ongoing care and resources.[119] An example of this is people suffering heart attacks that used to be fatal now surviving and needing care for the rest of their lives.[120]

3.20 In its submission to this inquiry, the Australian Medical Association of New South Wales told the committee that people aged 65 years and over contribute 50 per cent of admitted bed days in New South Wales. Yet, the ratio of available hospital beds per 1,000 people aged 65 years and over 'has been in a trend of decline for decades.'[121] The Association's President, Dr Michael Bonning, said: 'What we see is that that availability of beds per 1,000 people aged 65 years and over has halved from the early 1990s to now.'[122]

114 Submission 15, The Society of Hospital Pharmacists of Australia (SHPA), p 1.

115 Evidence, Mr Yik, 7 October 2022, p 14.

116 Evidence, Dr Liz Swinburn, Senior Emergency Physician, Royal North Shore Hospital, 7 October 2022, p 14.

117 Evidence, Dr Tony Sara, President, Australasian Salaried Medical Officers' Federation, 5 October 2022, p 15.

118 Media release, Hon Brad Hazzard MP, Minister for Health, 'Pharmacy reform to expand community health care,' 22 November 2022', www.health.nsw.gov.au/news/Pages/20221113_00.aspx (accessed 17 November 2022).

119 Submission 10, Name Suppressed, p 2.; Evidence, Mr Chris Kastelan, Paramedic on Central Coast and President, Australian Paramedics Association (NSW), 5 October 2022, p 16

120 Evidence, Dr Clare Skinner, President, Australasian College for Emergency Medicine, 5 October 2022, p 5.

121 Submission 33, Australian Medical Association (NSW) Ltd, p 2.

122 Evidence, Dr Bonning, 7 October 2022, p 3.

3.21 The Australian Medical Association's Public Hospital Report Card confirms that across Australia the number of public hospital beds for every 1,000 people over the age of 65 has dropped from 30 to less than 15.[123]

3.22 Dr Bonning added:

> That group is and has always been over-represented with regard to the use of hospital services. That is a function of ageing. We cannot change that, but what we need to change is the way in which we think about chronic disease management within the spectrum of the hospital system and not just primary care.[124]

3.23 Socioeconomic factors are another important component. Professor James Mallows presented evidence to the committee showing that there are around twice as many hospitals in Sydney's east as in its west. He concluded that how EDs perform is not simply a matter of the resources provided to each hospital but is 'related to resources surrounding that hospital—for example, other nearby hospitals, good access to GP services, access to specialist services and access to residential aged care facilities.'[125]

3.24 Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, added: 'When the population shifts or rapidly expands, like in south-west Sydney, and there's the 12-monthly budget cycle that says, "Yes, we recognise that. Let's resource it a bit more," there is a lag to staff these beds, to recruit the staff to fill them. Unfortunately, the area that bears the brunt of this lag is the emergency department.'[126]

3.25 Bed numbers are discussed in more detail below from paragraph 3.44.

Community care and emergency department presentations

3.26 An example of the relationship between community-based care, ambulance ramping and how EDs perform can be found in the evidence in this inquiry discussing 'GP-type' patients – patients with symptoms that should be treated by GPs or other primary care providers. The issue is introduced here, with detailed discussion of community-based care (primary health care, mental health aged care and National Disability Insurance Scheme (NDIS) clients) in the final chapter of this report.

3.27 The committee heard conflicting evidence on the impact of these patients on EDs in New South Wales. For example, some pointed to the fact that while low-acuity presentations (ATS 4 and 5) may wait longer to be treated, thereby increasing the risk of inadequate care, they take up

123 Australian Medical Association, *AMA Public Hospital Report Card 2022* (9 May 2022), https://www.ama.com.au/articles/ama-public-hospital-report-card-2022, accessed 25 October 2022.

124 Evidence, Dr Bonning, 7 October 2022, p 3.

125 Evidence, Associate Professor James Mallows, Staff Specialist Emergency Physician and Director Emergency Medicine Research, Nepean Hospital, 7 October 2022, p 17.

126 Evidence, Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, 5 October 2022, p 38.

relatively few resources.[127] Professor James Mallows reported that 'these patients require at most 3 per cent of the total ED resources.'[128]

3.28 On the other hand, others argued that patients who could be seen by a GP or others in the primary health care system (including GPs, mental health, allied health, clinical pharmacy/ pharmacists, paramedics), can contribute to ED overcrowding and, potentially, ambulance ramping. For example, Associate Professor Ray Bange argued that the increase in general presentations at EDs is major cause of 'bottlenecks' that create ambulance ramping and access block.[129]

3.29 Mr John Bruning, the Australasian College of Paramedicine's Chief Executive Officer, told the committee that the health system has not fully appreciated the fact that paramedics became a registered health profession four years ago. He said that paramedics have the potential to contribute more to community health care than is currently the case.[130]

3.30 A number of inquiry participants highlighted the benefits of the Extended Care Paramedic (ECP) program to deliver more at-home care to patients, away from hospitals, and expressed desire for the program to be expanded. For example, the Australian Paramedics Association gave evidence that:

> For every patient diverted from an emergency department, the Extended Care Paramedic (ECP) program saves the health system money, reduces pressure on the hospital system, and provides at home care to patients, helping them avoid costly and stressful visits to hospital. ECPs can provide antibiotics, fix catheters and gastronomy tubes, do sutures, address dislocations, and more. Despite the evident value they bring in avoiding transfers to hospital, the ECP program is routinely ignored by NSWA[mbulance].[131]

3.31 The Australasian College of Paramedicine particularly highlighted the ability of ECPs to provide at-home care for the ageing population, to assist rural and regional New South Wales:

> There is scope for Community/Extended Care Paramedic roles to be expanded in metropolitan, rural and remote communities, hospitals and health clinics, aged care and other critical primary health care settings. Expansion of these models of care could support hospital avoidance initiatives and potentially reduce costs to the health system associated with emergency department presentations. Additionally, it would improve chronic health conditions' management and reduce early entry into aged care.[132]

3.32 The Australian Paramedics Association also raised concerns regarding the management of the ECP program prohibiting the training or transfer of ECPs in the regions, stating:

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127 For example see: Submission 16, Australasian College for Emergency Medicine, p 3; Submission 20, Dr Kendall Bein, pp 6-7; Submission 29, ASMOF NSW - the Doctors' Union, p 3; Submission 33, Australian Medical Association (NSW) Ltd, pp 5-6.

128 Submission 26, Professor James Mallows, p 17.

129 Evidence, Associate Professor Bange, OAM, 5 October 2022, pp 26-27.

130 Evidence, Mr John Bruning, Chief Executive Officer, Australasian College of Paramedicine, 5 October 2022, p 14.

131 Submission 19, Australian Paramedics Association (NSW), p 14.

132 Submission 28, Australasian College of Paramedicine, p 9.

> NSWA[mbulance] has recently notified APA (NSW) that they intend to place location limits on specialist positions, disallowing specialists from moving between stations unless to an "identified" specialist position. To the knowledge of APA (NSW), there are no formally funded/identified ECP positions outside Sydney, Wollongong and Newcastle. This could mean that if any ECP wishes to move to a regional location, they may be forced to give up their specialist credentials.[133]

3.33 Both Mr Bruning and Associate Professor Ray Bange argued that New South Wales should follow Victoria's lead in establishing the position of Chief Paramedic Officer. Mr Bruning told the committee:

> In Victoria we have the one and only chief paramedic officer, who sits separate of the ambulance service and is able to provide advice as to how paramedics can be utilised in new, innovative and different ways. We saw through the initial start of COVID that it actually made a significant difference because paramedics were able to utilise much more widely than emergency response and to support the health system with taking care of COVID patients. We were able to leave nurses in hospital and those sorts of things.[134]

3.34 Associate Professor Bange argued that a Chief Paramedic Officer 'stands independently and is able to provide an input that takes into account not only the public ambulance service but also the private paramedics who are working out there in the field.'[135]

3.35 Problems can also occur with patients' conditions deteriorating because of a lack of primary care options, especially in regional areas, leading to them presenting at EDs with severe symptoms that ideally would have been treated earlier.[136]

3.36 Similar problems were identified in relation to the NDIS and residential aged care facilities (RACFs). Dr Bonning told the committee that while the decrease in bed numbers for patients aged over 65 years is important to address 'it is also the systems that sit around it to prevent unplanned hospitalisation that can make the biggest impact on changing the way in which people present to hospital and how we manage them.'[137]

3.37 The Australian Paramedics Association said that many RACFs lack the appropriate resources and skills to provide full-time care to their residents. It said that facilities with 24-hour RNs, for example, call 000 far less often than those without full-time nurses. This results in low-acuity patients presenting in EDs and hospitals alongside patients needing treatment for more serious issues (for example, strokes and falls).[138]

3.38 A further issue raised by the Royal Australian and New Zealand College of Psychiatrists concerns the impact of the Matrix system on mental health admissions. Ambulances use to determine the closest and most clinically appropriate ED where they should take patients. The

133 Submission 19, Australian Paramedics Association (NSW), p 14.

134 Evidence, Mr Bruning, 5 October 2022, p 22.

135 Evidence, Associate Professor Bange, OAM, 5 October 2022, p 30.

136 See for example: Submission 10, Name Suppressed, p 1; Submission 28, Australasian College of Paramedicine, p 4; Submission 34, Health Services Union (NSW/ACT/Qld), p 4.

137 Evidence, Dr Bonning, 7 October 2022, p 3.

138 Submission 19, Australian Paramedics Association (NSW), p 13.

college submitted that the current system can lead to EDs receiving of out-of-area patients, meaning:

- the patients' local mental health team cannot assist with timely treatment
- the treating clinicians must spend time taking a medical history as electronic medical records are not accessible across LHDs.

3.39 The college argues these are contributing factors to access block and ambulance ramping in New South Wales.[139]

3.40 Lack of community care for patients also contributes to delays in patients being discharged, a major cause of access block in New South Wales. Delays typically happen when patients are ready to leave but don't have an appropriate place go to, or access to services, once released. As Taylor Fry pointed out in its submission, inadequate residential and community care both increases demand and 'prevents existing inpatients from being discharged and delays patients moving through the system.'[140]

3.41 Ms Shaye Candish told the committee that when patients are discharged without receiving appropriate follow-up care they are at greater risk of re-presenting. She said:

> The community system is also under strain and, at times, struggles to follow up patients and maintain thorough and consistent care. This results in readmissions via the emergency department, which then adds more pressure to ambulance services and, once again, wards and units. This is the nature of access or bed block.[141]

3.42 The committee also heard evidence of staff being pressured to discharge patients too early to clear inpatient beds, resulting in patients re-presenting and further adding to overcrowding and access block.[142] The committee understands that around 20 per cent of patients who leave an ED without, or before completing, treatment re-present within three days.[143]

Structural issues creating pressure on the health system

3.43 The evidence pointed to several structural issues creating pressure on the health system and contributing to poor patient flow. These include:

- bed numbers
- hospital occupancy rates
- discrepancy between ED operating hours and other hospital services
- insufficient integration of the different parts of the health system.

139 Submission 14, Royal Australian and New Zealand College of Psychiatrists, p 6.

140 Submission 23, Taylor Fry Pty Ltd, p 4.

141 Evidence, Ms Shaye Candish, General Secretary, NSW Nurses and Midwives' Association, 5 October 2022, p 42.

142 Submission 10, Name Suppressed, p 1.

143 Bureau of Health Information, Healthcare Quarterly April – June 2022.

Bed numbers

3.44 The committee heard that a big cause of problems with patient flow in New South Wales is a shortage of beds. One submitter told the committee: 'The main reason is lack of inpatient beds in the hospital stopping flow from the ED into the hospital.'[144]

3.45 Similarly, emergency physician Dr Kendall Bein stated: 'Ambulance ramping is caused by no empty beds in the ED. There are no empty beds in the ED because there are no empty beds on the wards to move the admitted patients to.'[145]

3.46 The issue of bed numbers is complicated by the fact that beds need to match the needs of patients, which change over time. The Australasian College for Emergency Medicine's (ACEM's) Dr Clare Skinner explained to the committee that the health system is divided into highly specialised services, meaning empty beds may not necessarily be suitable. She said: 'There is work we need to do on making sure we actually have beds available that match the care needs of the patients we have presenting for care now, not the theoretical needs of patients from a decade or two ago.'[146]

3.47 It is also important to note that in the health system the term 'beds' means physical beds as well as staff to take care of the patients in those beds. A lack of staff in wards means patients wait longer in EDs before being transferred, even if there is an empty physical bed in the hospital.

3.48 Dr Bonning told the committee that currently demand 'is exceeding supply in terms of both number of beds and having the right staff available to serve those beds, including in the emergency department and also in inpatient ward.'[147]

3.49 The Australian Medical Association of New South Wales called for extra beds and staff: 'The bottom line is that more hospital beds need to be supplied to help ease the emergency bottleneck created by access block. This must be coupled with investments in clinical workforce.'[148]

3.50 In response to further questions about what could be done to address the problem of patient flow, it responded:

> Providing additional funding for extra beds and staff to address current capacity issues. As explained above, a barrier to securing such additional funding is the current funding formula between the State and Federal Governments which is constraining the ability of public hospitals to address increasing demand pressures. AMA(NSW) calls for the NSW Government's support in urging the Federal Government to increase its contribution to funding as recommended in our submission.[149]

3.51 Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, underscored that it is not just additional physical beds that are needed, but

144 Submission 3, Name Suppressed, p 1.

145 Evidence, Dr Kendall Bein, Emergency Department Staff Specialist, 7 October 2022, p 17.

146 Evidence, Dr Skinner, 5 October 2022, p 9.

147 Evidence, Dr Bonning, 7 October 2022, p 2.

148 Submission 33, Australian Medical Association of NSW, p 12.

149 Answers to questions on notice, Australian Medical Association of NSW, 8 November 2022, p 4.

the staffing to commission physical beds that already exist. When asked what the NSW Government could do today to assist his Local Health District, Dr Ung responded:

> Accelerate commissioning of the already built physical beds in SWSLHD facilities that have completed the capital works of their redevelopment cycles; especially for those facilities that are constantly operating at or over occupancy rates of 100%. Resourcing of these beds even when budgetary enhancements are handed down through the normal channels incur lengthy delays due to cumbersome recruitment and signoff processes. As recruitment and retainment for hospital clinicians for all health disciplines to work in South Western Sydney is slow and difficult at the best of times; budget enhancements need to be delivered expeditiously and not held back.[150]

3.52 The committee did not receive data on the number of beds lost across the state over recent decades. The committee has not included data about the overall number of beds needed in New South Wales. This is because each hospital is unique and, therefore, bed numbers can only be determined on a case-by-case basis.

Hospital occupancy rates

3.53 Another structural issue creating pressure on the health system is hospital occupancy rates. The committee was told that patient flow is most effective when hospitals are at around 85 per cent occupancy, as opposed to the current rate for most hospitals in New South Wales of 100 per cent.[151] Staying at around 85 per cent occupancy provides a 'surge capacity' that allows EDs to transfer patients in busy times. However, when hospitals are permanently full, no such capacity exists.

3.54 Dr Tony Sara from the Australian Salaried Medical Officers' Federation said: 'Many hospitals these days run at 100 per cent or greater than 100 per cent occupancy. It becomes impossible to run an efficient system. It's impossible to put patients into beds if they aren't there …'[152]

3.55 Dr Kendall Bein explained: 'If there is 85 per cent occupancy at an equilibrium state on the wards, that means there are empty beds to go to for admitted patients. We never have a situation where there are more ambulances ramped than there are admitted patients waiting for ward beds in the ED.'[153]

3.56 The terms 'surge capacity' and 'equilibrium state' refer to the fact that there will be times of unexpected demand when the hospital has to operate at above 85 per cent. The aim then is to return to the 85 per cent figures as soon as possible.

3.57 Professor James Mallows explained this to the committee, saying:

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150 Answers to questions on notice, Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, p 5.

151 Submission 16, Australasian College for Emergency Medicine, p 5; Submission 20, Dr Kendall Bein, p 4; Submission 26, Professor James Mallows, p 10. Hospitals are said to be at over 100% occupancy when there are patients waiting to be transferred from ED to wards.

152 Evidence, Dr Sara, 5 October 2022, p 9.

153 Evidence, Dr Bein, 7 October 2022, p 19.

> If you have a really, really busy day and get smashed, maybe you're going to trend up a little bit with the aim to try and get back down to that 85 per cent at a later time in the week because there are variations in presentations … We got smashed by COVID; we got smashed by the floods at Nepean Hospital. The 85 per cent should be seen as some kind of built-in surge capacity to build in so the difference is in processing the ED and the surges that the ED can have and the differences in processing on the wards.[154]

Operating hours

3.58 The committee also heard about the 'underlying friction' within a health system that sees EDs operate 24 hours a day, seven days a week. However the majority of the rest of the system, in particular other parts of the hospital, functions across a Monday–Friday daytime work structure, with afternoon and night shifts designed to carry everything forward to the next morning (or Monday morning if working on weekends). This causes problems when patients are ready to leave ED but hospitals aren't ready to take any patients, as well as creating delays when patients are ready to be discharged from hospital.[155]

3.59 Dr Skinner explained that many acute and allied health services in hospitals will have a 'skeletal staff' after 4.30 pm. While Dr Skinner acknowledged that, for example, surgeries are best performed when staff are rested and fully present 'there can be delays accessing care [and] people can wait for days.'[156]

3.60 Professor Mallows told the committee that wards at Nepean Hospital won't accept interhospital transfers beyond 9 pm 'after which interhospital transfers transit through the ED for the initial workup.'[157]

3.61 Dr Pramod Chandru and Dr James Tadros suggested that 'the ability of these systems to flourish is both funding dependent and dependent on a shift in the long-standing inertia of the medical fraternity regarding this issue.'[158]

3.62 Mr James Gray, Manager – Policy and Advocacy, ACEM, added: 'It is just the way our society is structured, our economy is structured; we tend to just work within fairly set hours. That just doesn't match with health needs.'[159]

Integration of the health system

3.63 The committee heard evidence that different parts of the health system do not fully understand how each other operate, nor the unique pressures they each face, and greater cooperation is needed to enhance patient flow.

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154 Evidence, Associate Professor James Mallows, 7 October 2022, p 20.

155 Submission 21, Dr Pramod Chandru and Dr James Tadros, p 2.

156 Evidence, Dr Skinner, 5 October 2022, p 7.

157 Submission 26, Professor James Mallows, p 2.

158 Submission 21, Dr Pramod Chandru and Dr James Tadros, p 5.

159 Evidence, Mr James Gray, Manager – Policy and Advocacy, Australasian College for Emergency Medicine, 5 October 2022, p 7.

3.64 Professor Middleton explained that patients experience the health system as a 'seamless' and 'horizontal', from ringing 000 to being discharged. However in reality, the system is constructed of 'sequential silos' that do not communicate well with each other or understand how the other silos function. Professor Middleton observed:

> Even when a subsequent silo utilises data from a preceding one, there is almost always no feedback and loop closure, to increase the efficiency of the system. The NSW Ambulance Service is a separate and non-integrated silo separate from EDs, however EDs are structurally and functionally separate from all other units in the hospital.[160]

3.65 Ms Sophie Dyson from Taylor Fry also identified a gap in understanding between different parts of the health system. She told the committee that what is needed for these parts to better understand how they interact with each other 'is for everyone to sit down and have a common understanding of the situation and the end-to-end process that we go through here. If you only see something from your own perspective, it's difficult to understand the consequences of your actions.'[161]

3.66 ACEM was one of several stakeholders to argue that system-wide problems require system-wide solutions.[162] It stated that ambulance ramping and ED overcrowding are 'typically due to a lack of understanding and ownership of access block by in-patient teams and executives.'[163]

3.67 The Australian Paramedics Association of New South Wales pointed out that cooperation depends to an extent on the relationships between EDs and hospital wards. It said that currently when access block is a problem a Health Relationship Manager (HRM) and/or Duty Operations Manager (DOM) may work with senior hospital management to discuss potential solutions. In its submission, the association wrote: 'This has mixed results, generally relying on the strength of the relationships between the HRM or DOM with hospital senior management.'[164]

3.68 Similarly, Mr Gerard Hayes from the Health Services Union (NSW/ACT/Qld) described health as 'a holistic system where one group relies on another group. If that system doesn't work collaboratively, it just becomes chokage point after chokage point.'[165]

3.69 The South Western Sydney Local Health District Medical Staff Executive Council suggested that no improvements can be made 'without innovative service development and coordination between our hospital based systems.'[166]

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160 Professor Paul M Middleton, Director, South Western Emergency Research Institute, 'Summary of a verbal brief to the Inquiry into the impact of ambulance ramping and access block the operation of hospital emergency departments in New South Wales', September 2022, p 2.

161 Evidence, Ms Sophie Dyson Director, Taylor Fry Pty Ltd, 7 October 2022, p 28.

162 For example see: Submission 20, Dr Kendall Bein, p 1; Submission 33, Australian Medical Association (NSW) Ltd, p 11.

163 Submission 16, Australasian College for Emergency Medicine, p 3.

164 Submission 19, Australian Paramedics Association (NSW), p 16.

165 Evidence, Mr Gerard Hayes, Secretary, Health Services Union (NSW/ACT/Qld), 5 October 2022, p 47.

166 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 9.

3.70 In its submission to this inquiry, Taylor Fry said that an opportunity exists to use linked data to help better understand how different parts of the health system interact. Taylor Fry informed the committee that it is currently working with NSW Health on several projects with this aim in mind.[167]

3.71 The South Western Sydney Local Health District Medical Staff Council Chairs warned that without innovation and better cooperation across the whole health system 'the ongoing struggles resulting in ambulance ramping and access block for patients who ultimately have no other option than to seek their health care via our SWSLHD EDs will never come to an end.'[168]

3.72 Professor Mallows suggested that publishing data showing how access block causes delays in EDs would help the public understand that patient flow problems reflect problems across the whole health system, not just within EDs.[169]

3.73 Ms Pearce told the committee that NSW Health recognises that patient flow is a shared responsibility, not the sole responsibility of EDs. She said: 'We focus on our whole hospital because our emergency department staff need to understand clearly from us that this is not all resting on their shoulders.'[170]

3.74 Ms Pearce added: 'I've been in the health system, like many of my colleagues, for a long time. What is clear to me in this environment is that if we keep trying to replicate things that we've historically done, it just will not work. We have got to try new ways of doing things and new models.'[171]

3.75 The committee asked Dr Bein who should take responsibility to drive the changes needed to improve patient flow in New South Wales. He answered that the direction must come from the state government which, importantly, must understand and accept that all new ideas go through periods of adjustment before they become fully effective. Dr Bein added that only then will hospital executives feel confident to participate and contribute to change, telling the committee:

> I think that since the approach at least requires buy-in from the hospital executives—and those hospital executives are not going to be willing to take risks, bear extra expenses and hand over power without something else—it actually needs to come at State level to say, "Look, this is what needs to be approached. We need to trial something; here is an approach."[172]

3.76 The committee learnt of several examples of innovation during this inquiry. One such example presented a new way of measuring delays experienced by patients ready to leave EDs is through

167 Submission 23, Taylor Fry Pty Ltd, p 9.

168 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 9.

169 Submission 26, Professor James Mallows, p 21.

170 Evidence, Ms Pearce, 7 October 2022, p 36.

171 Evidence, Ms Pearce, 7 October 2022, p 39.

172 Evidence, Dr Bein, 7 October 2022, p 22.

the concept of lost bed capacity (LBC). The committee heard that an LBC 'heatmap' can provide hourly updates on the impact of external factors on specific beds and patient groups.[173]

3.77 Another example of innovation is inputting data into 'agent-based modelling' and 'digital twins'. This technology accurately shows how changes in one part of the health system – such as hiring more senior staff or introducing weekend discharges – affect other parts of the system, without having to make any physical changes or undertake long-term trials. Once the modelling shows what actions do and do not improve patient flow, actual changes can be introduced to the health system.[174]

3.78 Ms Dyson, Director at Taylor Fry, expanded on the benefits of 'digital twins':

> The 'Digital Twins' concept is used in multiple industries. A digital twin is a virtual representation of a real-world physical system that serves as the digital counterpart for practical purposes and can be used to review operational strategies, capacities, staffing and care models, identify areas of improvement or predict future challenges, and optimise the organisational response. Digital Twins can be constructed to represent specific parts of the health system, such as an ED or a hospital.
>
> NSW Health has a patient flow portal to guide the transition of patients through the system, but (as I understand it) this relies on information being entered by clinicians. A more efficient and effective way of managing patient flow is to use real-time and predictive data in Digital Twins to manage hospital operations. This approach has been successfully introduced by the Johns Hopkins Hospital in the US, within their Capacity Command Centre. In Australia, a similar approach is being trialled at the Royal Melbourne Hospital.[175]

Staffing

3.79 The committee received evidence on how staffing in EDs and hospitals affects ambulance ramping and access block.

Staff numbers, seniority and expertise

3.80 The evidence revolved around staff numbers and their seniority and expertise. For example, the Health Services Union (NSW/ACT/Qld) identified understaffing as a problem and a major concern for staff.[176] In her submission to this inquiry, Mrs Suzanne Mechior, a Senior Registered Nurse in the Northern Rivers area, explained how vacancies in her hospital roster can cause ambulance ramping, especially during the night shift.[177]

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173 Professor Paul M Middleton, Director, South Western Emergency Research Institute, 'Summary of a verbal brief to the Inquiry into the impact of ambulance ramping and access block the operation of hospital emergency departments in New South Wales', September 2022, p 3.

174 Professor Paul M Middleton, Director, South Western Emergency Research Institute, 'Summary of a verbal brief to the Inquiry into the impact of ambulance ramping and access block the operation of hospital emergency departments in New South Wales', September 2022, p 6.

175 Answers to questions on notice, Ms Sophie Dyson, Director, Taylor Fry, 24 October 2022, p 3.

176 Submission 34, Health Services Union (NSW/ACT/Qld), p 1.

177 Submission 12, Mrs Suzanne Melchior, p 1.

3.81 The seniority and expertise of staff is important for several reasons. Firstly, senior doctors make decisions faster than junior doctors. Associate Professor Graham Reece, an Intensive Care Specialist at Blacktown Hospital, informed the committee of a review of the health system in Scotland which found that a registrar-based system is 70 per cent efficient whereas a consultancy-based system is 95 per cent efficient.[178]

3.82 As well, specialists need to double check the decisions of junior doctors than they are with senior doctors. Dr Reece added: 'If I get a call from my emergency department from the consultant, in five minutes I will accept that patient because what he says is gold ... If I get a call from somebody else and what they say is contradictory all the time, I might even ask for more tests. So [patient] flow is only a product of high-quality decision-making.'[179]

3.83 Making the right decisions as early as possible is critical. Dr Skinner said that 'the vast majority of care in public hospitals is provided by junior and training doctors, not by qualified specialist doctors … They provide very good care and they are very dedicated, but people can often wait days for a specialist-level decision, which can be a major hold-up as well.'[180]

3.84 Professor Mallows told the committee that there are 'stark differences' in staffing numbers and seniority between hospitals in Sydney's east and west.[181]

3.85 Stakeholders, including the NSW Nurses and Midwives' Association, argued that minimum staff-to-patient ratios must be part of the solution when it comes to addressing bed block and ambulance ramping:

> It is clear the failure to reform staffing models for the nursing and midwifery workforce is a major barrier to resolving the crisis, and without addressing this we will continue to see poor patient outcomes and financial waste within the system. Shift-by-shift minimum enforceable safe staffing levels through the implementation of ratios is proven to be effective in improving patient care, improving patient outcomes, preventing adverse outcomes and deaths, recruiting and retaining staff and saving costs. It is the only measure that can break the cycle of nurses leaving the system as recruitment processes struggle to keep up with the loss of staff.
>
> Recent experience in Queensland following the introduction of ratios into adult medical and surgical wards in 27 public hospitals in 2016, demonstrates that this investment in nursing care leads to better patient outcomes, shorter length of stay and lower re-admission rates.[182]

3.86 The NSW Nurses and Midwives' Association also commented: 'Rather than responding to our ever-changing health system, the Nursing Hours Per Patient Day (NHPPD) staffing model continues to show that it is no longer fit for purpose. It is not transparent, and it is able to be manipulated.'[183]

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178 Evidence, Associate Professor Graham Reece, Intensive Care Specialist and Director, Intensive Care, Blacktown Hospital, 7 October 2022, p 28.

179 Evidence, Associate Professor Reece, 7 October 2022, p 28.

180 Evidence, Dr Skinner, 5 October 2022, p 7.

181 Evidence, Associate Professor Mallows, 7 October 2022, p 21.

182 Submission 31, New South Wales Nurses and Midwives' Association, p 3.

183 Submission 31, New South Wales Nurses and Midwives' Association, p 26.

3.87 The committee also received evidence about how the current pay and conditions for health care staff in New South Wales may be contributing to a loss of staff who move to other states, for example:

> Due to our proximity to the border, recruitment has become almost impossible. Why wouldn't nurses be attracted to better pay and conditions on offer in Qld? Many non-government nursing services in Qld have better pay and conditions than the LHD.[184]

3.88 The NSW Nurses and Midwives' Association argued that 'the government must ensure that nursing and midwifery pay rates are greater than those available to Queensland and Victorian nurses and midwives in order to slow the interstate migration out of NSW'.[185]

Measures to recruit and support staff.'

3.89 At a public hearing, the Secretary of NSW Health, Ms Susan Pearce, discussed with the committee how difficult it is to recruit senior staff. This is the case not just in New South Wales but in most parts of the world. Ms Pearce spoke of 'a lot of really excellent less experienced staff that we recruit every year', which she said NSW Health has the responsibility of supporting them to ensure they have a long career in the health workforce.[186]

3.90 Dr Sara told the committee that staff specialists in Queensland and Victoria are paid $50,000 more than in New South Wales,[187] attracting more senior doctors to those states.

3.91 Further, Dr Sara said: 'The New South Wales health system is based on the unrostered, unpaid wages theft of the hospital system of young doctors. That's been well and truly established. So it needs cultural change. It needs a new award.'[188]

3.92 NSW Health also addressed the issue of staffing in its submission to this inquiry. It referred to the cumulative effects of COVID-19 on staffing numbers and what was required to run clinics, wards, and testing, screening and mass vaccination centres.[189]

3.93 The number of staff furloughed throughout the pandemic because of catching COVID-19 or being a close contact was significant, peaking in mid-January 2022 at over 6,000 staff. This was particularly problematic in rural and regional areas 'where access to alternative workforce supply is limited and small workforce numbers means the loss of just one or two workers adversely impacts workforce availability.'[190]

3.94 The outbreak of the Omicron variant of COVID-19 was a significant challenge for staff. As at February 2022, sick leave represented 4.3 per cent of FTE hours across the health system in New South Wales, an increase of almost 1.8 per cent when compared to previous years. More

184 Submission 31, New South Wales Nurses and Midwives' Association, p 14.

185 Submission 31, New South Wales Nurses and Midwives' Association, p 5.

186 Evidence, Ms Pearce, 7 October 2022, pp 37-38.

187 Evidence, Dr Sara, 7 October 2022, p 12.

188 Evidence, Dr Sara, 7 October 2022, p 11.

189 Submission 35, NSW Health, p 17.

190 Submission 35, NSW Health, p 18.

variant surges were seen during April 2022, with sick leave accounting for 4.9 per cent of FTE, and June 2022. It has remained over 4 per cent.[191]

3.95 Further, staff were unable to take annual leave, adding to their stress and that on the system. As at June 2022, the percentage of staff with excessive annual leave (+30 days) has increased by 24 per cent when compared to the same period in 2020. There are currently more than 58,000 staff with an excessive leave balance, up by over 11,000 from June 2020.[192]

3.96 Ms Pearce explained that as the number of staff furloughed decreases more staff will be able to take leave. This in turn creates a new challenge of recruiting staff to cover those on leave.[193]

3.97 NSW Health told the committee that staff retention rates increased at the beginning of the pandemic. This is because many staff who may have planned to retire or change careers chose to stay to help with the response. Since then, however, there has been 'a decline in retention rates from February 2022. These retention patterns are not unique to NSW Health with health agencies across Australia and internationally reporting similar trends.'[194]

A health system no longer fit for purpose?

3.98 The large impact that the COVID-19 pandemic has had – and continues to have – on the New South Wales health system featured strongly in this inquiry. However, evidence presented to the committee argued that structural considerations and pressures on the health system have been building for many years due to underinvestment in public hospitals and community-based care.[195]

3.99 Some stakeholders stated that emergency health systems are designed to treat acute problems and not the wide range of health issues that currently present at EDs. This changing nature of emergency treatment, it was claimed, means the system is no longer 'fit for purpose.'[196]

3.100 Ms Candish told the committee:

> Having a system that fundamentally prioritises acute care, with very little investment in or focus on primary care and health prevention measures, means that we're continually having to pour money into a system that is constantly dealing with people at their sickest, rather than focusing on how we might start to prevent the increasing or worsening of health conditions before they're requiring acute care.[197]

3.101 ACEM's Dr Skinner told the committee that many places around the world are changing their understanding of how health systems are designed, with more care to be delivered 'in place' in the community. However, this change of approach requires increased funding for, and better

191 Submission 35, NSW Health, p 19.

192 Submission 35, NSW Health, p 19.

193 Evidence, Ms Pearce, 7 October 2022, p 38.

194 Submission 35, NSW Health, p 21.

195 For example: Evidence, Dr Skinner, 5 October 2022, p 3; Evidence, Mr Scott Beaton, Station Officer - Central West and Vice President, Australian Paramedics Association (NSW), 5 October 2022, p 14.

196 Evidence, Mr Bruning, 5 October 2022, p 14.

197 Evidence, Ms Candish, 5 October 2022, p 46.

coordination of, community-based care, which has not happened to the extent needed. As a result, EDs, which are open 24 hours a day and free at the point of care, take on patients who have nowhere else to turn.[198]

3.102 Dr Skinner said:

> I think that's a common vision across the world, which is hospitals become smaller, the vast majority of people will be cared for in their own homes or in community-based settings. It sounds easy, but the reality is that that requires more resources, more coordination and very sophisticated digital mechanisms to be able to do that. We have been trying to shift towards that by cutbacks through efficiency and lean thinking in the public hospital system. You can't drive those efficiencies through setting smaller and smaller targets. You actually need to put the work into clinical redesign, change management and transformative health care.[199]

3.103 Similarly, the Secretary of NSW Health, Ms Pearce, who has a background in nursing, said: 'Models of care have changed substantially over time. People's length of stay in a hospital has reduced. We've changed the way we operate compared to what it was like when I was nursing some years ago, and that's how health systems of the future will need to continue to look.'[200]

3.104 Mr Matthew Daly, NSW Health's Deputy Secretary, Patient Experience and System Performance, gave the example of 'day-only hip and knee replacements were unheard of back in the 2000s and nineties. It partly contributes to why we don't need as many beds.'[201]

3.105 Dr Bonning observed that while hospitals are best placed to provide high-acuity care, chronic disease is 'best managed in the community, near where the patient lives and by someone who has a longitudinal relationship with them.'[202]

Current measures being undertaken by NSW Health

3.106 This section examines the effectiveness of current measures being undertaken by NSW Health to address the root causes of ambulance ramping, access block and emergency department delays, as described in this chapter.

Understanding and responding to the problem

3.107 NSW Health told the committee that the HealthShare NSW Patient Transport Service liaises with Local Health Districts (LHD)s twice daily 'to understand local demand, pressure areas and priorities to best support effective patient flow.'[203]

198 Evidence, Dr Skinner, 5 October 2022, p 6.

199 Evidence, Dr Skinner, 5 October 2022, p 9.

200 Evidence, Ms Pearce, 7 October 2022, p 41.

201 Evidence, Mr Matthew Daly, Deputy Secretary, Patient Experience and System Performance, NSW Health, 7 October 2022, p 43.

202 Evidence, Dr Bonning, 7 October 2022, p 4.

203 Submission 35, NSW Health, p 26.

3.108 It added that transfer of care is monitored through annual service agreements between NSW Health and LHDs and Specialty Health Networks (SHN)s. The agreements are part of the NSW Health Performance Framework.[204]

3.109 NSW Health, LHD and SHN staff monitor real-time performance through the 'ambulance dashboard' on the Patient Flow Portal, recently developed technology which shows information such as where ambulances are waiting to transfer care and how long they have been waiting.[205]

3.110 In addition, LHDs and SHNs are required to escalate transfer of care delays to NSW Health when:

- ambulance delay has reached 90 minutes with no transfer of care plans within the next 30 minutes
- hospital capacity means that significant delays are likely to occur
- there are critical infrastructure or operational issues that affect patient flow.[206]

3.111 Transfer of care performance is a service agreement KPI for all LHDs and SHNs (excluding Justice Health and the Forensic Mental Health Network). However, the South Western Sydney Local Health District Medical Staff Council Chairs warned against having transfer of care times as a KPI, as this does not measure the quality of care patients are receiving. Further, there is a risk that patients will call an ambulance, even if they are able to self-present, knowing that they will be prioritised.[207]

3.112 Dr David Waters, Chief Executive, The Council of Ambulance Authorities, told the committee that the relationship between NSW Health and NSW Ambulance is 'a best-practice example.' He said: 'It is an exemplary example of a commitment of senior executives in both the health department and the ambulance service to put the patient at the centre of their care and try to minimise transfer delay in any way they can.'[208]

3.113 ACEM commended the work being done by the NSW Ministry of Health, and called on LHDs and hospital executives to become more familiar with the resources and strategies being developed by the Ministry:

> … we acknowledge that there is significant work underway in New South Wales (NSW) to address these problems. The development of clinical councils and communities of practices to embed senior clinicians in department of health decision-making is part of the right approach and this needs to continue. It is clear from our perspective that the leadership team at NSW Health, particularly through the system performance branch and the Whole of Health Program, have a strong understanding of the issues.
>
> This begs the question of why further inroads have yet to be made. We highlight the necessity of supporting Local Health District and hospital executives to understand the problem and to avail themselves of the resources and strategies being developed by the

204 Submission 35, NSW Health, p 32.

205 Submission 35, NSW Health, p 32.

206 Submission 35, NSW Health, p 32.

207 Submission 35, NSW Health, p 7.

208 Evidence, Mr David Waters, Chief Executive, The Council of Ambulance Authorities Inc, 5 October 2022, p 29.

> Ministry. As committee members may be aware, there has been significant staffing turnover in these senior positions in the last several years, and this often comes with a process of bringing those new executives up to speed on understanding and managing this complex problem.
>
> Ongoing professional development in patient flow for Local Health District (LHD) and hospital executives under the auspices of the Ministry would support the appropriate implementation of the strategies that have already been developed. Change management can be complex in health care and it is essential that it receives focused and funded attention in order to be successful.[209]

3.114 NSW Health's submission outlined several processes that are in place across the health system to respond to delays as they arise.

NSW Ambulance's system of escalation

3.115 NSW Ambulance's system of escalation relies on local and senior level relationships facilitated by local NSW Ambulance Health Relationship Managers. The Health Relationship Manager's role is to establish and maintain close working relationships with hospitals and stakeholders, to improve working partnerships between NSW Ambulance and primary health providers.[210]

NSW Health Patient Allocation Matrix

3.116 Ambulance patient flow is managed through the NSW Health Patient Allocation Matrix in greater Sydney, Lower Hunter region, Central Coast and the Illawarra. The 'matrix' considers a variety of criteria, including patient acuity, clinical transport category, ED capacity for ambulance arrival and location. It is reviewed twice a year.[211]

The Emergency Care Institute

3.117 The Emergency Care Institute aims to promote, facilitate and share research and quality improvement activities that improve the way emergency care is provided, including working with clinicians to help New South Wales respond to system challenges experienced by clinicians working in EDs.[212]

NSW Health Whole of Health Program

3.118 The Whole of Health Program invests $2.4 million annually to help LHDs and SHNs establish patient flow governance, identify current challenges and design locally tailored solutions.[213]

3.119 The President of ACEM, Dr Clare Skinner, said that the Whole of Health Program is an example of the 'significant work that has been done by NSW Health' to address patient flow problems.[214]

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209 Answers to questions on notice, Dr Clare Skinner, President, Australasian College for Emergency Medicine, 7 November 2022, pp 1-2

210 Submission 35, NSW Health, p 34.

211 Submission 35, NSW Health, p 33.

212 Submission 35, NSW Health, p 34.

213 Submission 35, NSW Health, p 35.

214 Evidence, Dr Skinner, 5 October 2022, p 8.

Dr Skinner added: 'We do have the advantage in New South Wales of the LHD structure, which means we're fairly well integrated.'[215]

Short Term Escalation Plans

3.120 The Whole of Health Team provides support to LHDs and SHNs to review and update Short Term Escalation Plans (STEP). STEP plans aim to manage short-term demand and capacity mismatches.[216]

NSW Health System Flow Centre

3.121 The NSW Health System Flow Centre also supports LHDs and SHNs to coordinate whole-of-system patient flow during peak activity periods. It monitors ED, acute hospital and intensive care unit capacity to guide patient distribution and improve ambulance offload times, ED performance and whole-of-system patient flow.[217]

The Lumos Program

3.122 The Lumos Program links deidentified data from general practices with other health service data to provide a more comprehensive view of patient pathways.[218]

Discharge delays

3.123 NSW Health told the committee about two ways in which it is working to improve discharge processes in hospitals:

- Criteria Led Discharge: enabling patients to be discharged according to documented criteria without the need for a further review by a specialist
- Waiting for What: a project that developed a patient flow self-assessment tool to help hospitals identify targeted areas for improvement in patient flow.[219]

Fragmented funding – working with the Commonwealth

3.124 Under the National Health Reform Agreement all jurisdictions have committed to work in partnership to ensure the public hospital and primary care health systems work together more effectively. This includes:

- 10 Year Primary Healthcare Plan (Commonwealth): In March 2022, the Australian Government published its 10 Year Primary Healthcare Plan which commits the Commonwealth to working collaboratively with State/Territory governments to deliver quality healthcare.

215 Evidence, Dr Skinner, 5 October 2022, p 10.
216 Submission 35, NSW Health, p 42.
217 Submission 35, NSW Health, p 33.
218 Submission 35, NSW Health, p 47.
219 Submission 35, NSW Health, p 41.

- Urgent Care Clinics and Services: The Australian Government has committed to establishing Urgent Care Clinics across Australia, to take pressure off EDs. Alongside this, the NSW Government will establish 25 Urgent Care Services in partnership with GPs. These will operate for extended hours and patients will not be charged, even if they do not have a Medicare card. Where possible the Urgent Care Services will complement the Commonwealth's Urgent Care Clinics.[220]

3.125 The New South Wales Nurses and Midwives Association welcomed the announcements from the Australian and NSW Governments. It 'strongly recommends' recruiting qualified nursing staff for these services.[221]

Agency for Clinical Innovation

3.126 The Agency for Clinical Innovation brings 'patients, clinicians and managers together to support the design and implementation of innovation in healthcare.'[222]

3.127 The Agency's clinical directorates are:

- PRISM (Preserving and Restoring Interventions in Surgery and Medicine)
- CATALYST (Care Across the Lifecycle and Society).

3.128 It has system transformation directorates:

- STEP (System Transformation Enablement and Patient Partnerships) – This is different from Short Term Escalation Plans
- EVIDENCE
- SCOPE (Strategy, Communication, People and Engagement)
- IDEA (Integrated Digital Enablement Accelerator).

3.129 The committee notes that the agency's Strategic Plan 2019-2022 includes the following two items under the heading of 'complex system challenges':

- integrating care at the interface of hospital, primary, community and social care services
- delivering healthcare informed by shared decision-making and co-design.

Medical Staff Councils

3.130 All public hospitals in New South Wales have a Medical Staff Council (MSC) to:

- advocate for medical staff
- improve services and care for patients
- advise the hospital executive and LHD on providing medical services.

220 Submission 35, NSW Health, pp 37; 44.

221 Submission 31, New South Wales Nurses and Midwives' Association, p 12.

222 Agency for Clinical Innovation, www.aci.health.nsw.gov.au, accessed 14 November 2022.

3.131 The chairs of each MSC form the New South Wales Medical Staff Executive Council (NSW MSEC). The NSW MSEC 'focuses on provision of care in public hospitals and helping doctors to achieve an effective work environment and working relationship with management, NSW Health and the NSW Health Minister in order to deliver the best possible care for NSW patients.'[223]

Committee comment

3.132 The COVID-19 pandemic and natural disasters have placed significant stress on the New South Wales health system. The effect of the pandemic, in particular, has still not been fully overcome.

3.133 The committee acknowledges the remarkable efforts of healthcare staff during the COVID-19 pandemic. These frontline staff put their own health at risk, working under great stress for long hours while being unable to take leave. The committee believes that the health system should continue to do everything it can to support them so they can get on with what they do best: helping people.

3.134 However, the problems identified in this inquiry are long-term, pre-dating COVID-19.

3.135 A major cause of patient flow problems is a shortage of staffed beds in hospitals. While improvements in surgery and changing approaches to healthcare mean hospitals may not need as many beds as otherwise would have been the case, demand for beds exceeds supply. This simple equation has system-wide implications and is a significant contributor to ambulance ramping, ED overcrowding and access block.

3.136 The shortage in bed numbers is exacerbated by the fact that hospitals routinely operate at 100 per cent occupancy. Numerous stakeholders told the committee that ideally, hospitals should operate at around 85 per cent capacity, allowing them to accommodate periods of 'surge flow' or unexpected demand. A key recommendation of this inquiry is that the NSW Government increase bed numbers in public hospitals as a fundamental step to addressing ambulance ramping, ED overcrowding and access block. We urge the government to provide funding to increase staffed beds in public hospitals to achieve 90 per cent patient occupancy initially, progressing to a goal of 85 per cent occupancy.

Recommendation 2

That the NSW Government commit to provide funding to increase the number of staffed beds in public hospitals, with a goal of reducing patient occupancy to 90 per cent initially, and 85 per cent thereafter.

3.137 The committee is also concerned about the evidence received regarding the current pay and conditions of healthcare staff in NSW, and the risk that we may be losing experienced staff to other states due to better pay and conditions offered, which is likely to hamper efforts to increase staff in hospitals. The committee therefore recommends that the NSW Government abolish the wages cap for state sector employees, including junior doctors, paramedics, nurses, midwives and other healthcare staff, and move to a system of productivity-based bargaining, to

223 New South Wales Medical Staff Executive Council, www.nswmsec.com, accessed 7 November 2022.

deliver fair wages, productivity growth and better public services to the people of New South Wales.

Recommendation 3

That the NSW Government abolish the wages cap for state sector employees, including junior doctors, paramedics, nurses, midwives and other healthcare staff, and move to a system of productivity-based bargaining, to deliver fair wages, productivity growth and better public services to the people of New South Wales.

3.138 Patient flow is a system-wide problem requiring system-wide solutions. While bodies such as the Agency for Clinical Innovation and Medical Staff Councils provide some level of oversight, the committee remains concerned that there is no one role with responsibility for, and understanding of, how actions in one part of the system affect other parts. As acknowledged by the Secretary of NSW Health, Ms Susan Pearce, the old ways of addressing the problem are not working. The health system has to look for and initiate new ways of doing things, while accepting that some of them may not fully meet expectations at first.

3.139 The committee in particular points to the potential of data-driven technology to assess patient flow through EDs in real time. The committee also heard that technology can be used to predict how altering one part of the health system – such as hiring more senior staff or introducing weekend discharges – affects other parts of the system, without having to make actual changes or undertake long-term trials.

3.140 Another key structural issue is that EDs operate 24 hours a day, seven days a week, while other parts of the hospital work mostly fewer hours. This is a long-standing issue linked to numbers of medical professionals trained and the hours they work that should also be considered part of the system-wide solutions needed.

Recommendation 4

That the NSW Government appoint a person with oversight of patient flow with responsibility for identifying and reporting on system-wide initiatives to address patient flow. Initiatives to be trialled should include greater use of data modelling and expanded hours of operation for areas of the hospital other than emergency departments.

3.141 The evidence to this inquiry suggests that the health system is yet to fully appreciate recent changes in the professional status of paramedicine, with paramedics becoming increasingly independent in their work. Stakeholders suggested that independent representation for paramedics at a senior executive level would result in a better understanding of paramedics' skills and what they are qualified to contribute to emergency medicine. The committee did not receive enough evidence to make a final determination on this matter but believes there may be merit in this argument. It recommends that New South Wales follow Victoria's lead in establishing the position of Chief Paramedic Officer. This person could better advocate for the paramedic profession and may identify new ways in which paramedics can safely contribute solutions to patient flow problems.

Recommendation 5

That the NSW Government appoint a Chief Paramedic Officer based on the model in Victoria.

3.142 The committee also acknowledges the evidence received about the important role played by ECPs and their potential to help reduce pressure on hospitals. The committee feels that the ECP program is currently underutilised and recommends that the NSW Government invest in and expand the ECP program with a focus on assisting patients in aged care facilities, along with greater efforts to extend the program to rural and remote New South Wales.

Recommendation 6

That the NSW Government invest in and expand the Extended Care Paramedic program with a focus on assisting patients in aged care facilities, along with greater efforts to extend the program to rural and remote New South Wales.

3.143 The committee is concerned by NSW Ambulance's policies that are currently restricting the training and transfer of ECPs and Intensive Care Paramedics in regional New South Wales. We therefore recommend all location limits be removed to allow ECPs and Intensive Care Paramedics to retain their qualifications when transferring to regional areas.

Recommendation 7

That the NSW Government remove all location limits to allow Extended Care Paramedics and Intensive Care Paramedics to retain their qualifications when transferring to a regional location.

3.144 Hospital pharmacists are another profession that can play an important role in improving patient flow at multiple points: during the admission process, while patients are being treated and at discharge. However, there are not enough hospital pharmacists in New South Wales public hospitals and they do not work the same hours as EDs. The role of hospital pharmacists can be expanded through, for example, implementing Partnered Pharmacist Medication Charting. These changes have the potential to improve the patient experience and reduce the workload of ED staff, allowing them more time to treat patients. The committee therefore recommends that NSW Government provide funding to increase the number of public hospital pharmacists.

Recommendation 8

That the NSW Government provide funding to increase the number of public hospital pharmacists so that their availability better matches the operating hours of emergency departments. The government should also consider implementing Partnered Pharmacist Medication Charting in hospitals.

3.145 New South Wales is yet to become a signatory to the Commonwealth's Pharmaceutical Reform Agreements. In other states and territories that are signatories hospitals can dispense a larger amount of medication to patients on discharge than in New South Wales. This both improves

patient wellbeing and reduces the risk of patients re-presenting to EDs if their medication runs out. We recommend that the NSW Government become a signatory to the Commonwealth's Pharmaceutical Reform Agreements.

Recommendation 9

That the NSW Government become a signatory to the Commonwealth's Pharmaceutical Reform Agreements.

Chapter 4 Primary care

This chapter discusses how issues affecting primary care, in particular GP shortages, mental health care, aged care and the National Disability Insurance Scheme (NDIS), are impacting on patient flow in public hospitals.

The chapter finds that a combination of issues around access to these services, or inefficiencies in how they are delivered, contribute in their own particular ways to ambulance ramping, emergency department (ED) overcrowding and access block.

The chapter notes that most of the responsibility for these areas, particularly GPs, aged care and the NDIS, resides with the Commonwealth, although all jurisdictions seek to work constructively and cooperatively to address them.

Access to primary care services

4.1 As mentioned in chapter 2, the committee heard a range of views on the links between primary care services and in particular GPs and ambulance ramping, ED overcrowding and access block.

Preventable and non-urgent presentations to emergency departments

4.2 It has been estimated that in 2020–21, there were 672,000 potential preventable hospitalisations in public hospitals and 156,000 in private hospitals across Australia.[224] The committee heard that in New South Wales some patients attend EDs because they either cannot access primary care services, in particular GPs, because of a shortage where they live or their local GPs do not bulk bill, making them unaffordable.[225]

4.3 The Australasian College of Paramedicine said that 'providing care to even a subset of these patients in the community through Urgent Care Centres, GPs, and multidisciplinary teams would deliver considerable savings to the NSW health system.'[226]

4.4 In its submission, Taylor Fry referred to data from the Australian Institute of Health and Welfare which found that 38 per cent of ED presentations in New South Wales in 2018-19 were for lower-urgency care.[227] It advised: 'This does not translate directly to patients that could have seen their GP, because there are other factors that influence the choice of treatment location, but it is indicative.'[228]

224 Australian Institute of Health and Welfare, *Hospital safety and quality*, https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-safety-and-quality, accessed 27 October 2022

225 Submission 34, Health Services Union (NSW/ACT/Qld), pp 3-4.

226 Submission 28, Australasian College of Paramedicine, p 7.

227 Australian Institute of Health and Welfare. Use of emergency departments for lower urgency care: 2015–16 to 2018–19. Canberra: AIHW, 2020.

228 Submission 23, Taylor Fry Pty Ltd, p 5.

4.5 The Australian Medical Association of New South Wales also included data from the Australian Institute of Health and Welfare in its submission showing that the number of non-urgent presentations to EDs in New South Wales increased by 9.8 per cent from 2018–19 to 2019–20 and by another 12 per cent from 2019–20 to 2020–21.[229] As well, an Australian Bureau of Statistics' Patient Experience Survey conducted for 2018–19 revealed that:

- 16.8 per cent of respondents aged 15 and over who visited EDs thought their care could have been provided by a GP
- 21 per cent said that the main reason for attending an ED was because a GP was not available.[230]

4.6 NSW Health advised the Committee of data collected from surveys of COVID-19 patients being transferred to primary care and from patients calling COVID-19 and influenza support lines. The data revealed:

- Between May and July 2022, 66 per cent of cases who called HealthDirect and were referred to a GP were unable to book an appointment within required timeframes. This can adversely impact demand for EDs with increases in presentations.
- Around 25 per cent of high-risk patients did not nominate a primary care provider or GP as their regular healthcare provider. Of those being connected to primary care, with a regular GP, 30 per cent of patients were unable to be connected to their GP due to a lack of after-hours and weekend access and/or their GP not conducting COVID-19-related care.
- Patients calling the NSW Health Flu & COVID-19 Care at Home Support line reported that 49 pr cent of callers had tried to book a GP appointment but were unable to get one within the next 48 hours. Seven per cent of patients highlighted that their GP refused to see patients with respiratory symptoms.[231]

4.7 According to NSW Health, the data suggests that 'limited access to primary care influences the likelihood of EDs presentations.'[232]

4.8 One submitter to this inquiry confirmed to the committee: 'In our area it is very difficult to access GPs. Patients will tell me at triage that they can't get in to see a GP for a week. This is also my experience. There is now no after-hours GP service in our area either.'[233]

4.9 Regarding regional New South Wales, the Australian Medical Association of New South Wales referred to data from 2017 showing:

229 Australian Institute of Health and Welfare, Emergency department care 2020-21 data, Table 2.2.

230 Australian Bureau of Statistics, Patient Experiences in Australia: Summary of Findings, 2018-19 financial year (Catalogue No 4839.0, 12 November 2019). Professor James Mallows told the Committee that the methodology used by the Australian Institute for Health and Welfare (referred to above) is 'seriously flawed' as it relies solely on triage category without a full understanding of the complexity of the patients' symptoms. Submission 26, Professor James Mallows, p 16.

231 Submission 35, NSW Health, pp 27-28.

232 Submission 35, NSW Health, p 27.

233 Submission 13, Name Suppressed, p 2.

- 80 per cent of people who had recently attended an ED cited the lack of GP availability when needed as the major reason for attending
- the probability of seeing a GP on the same day in north-eastern New South Wales was less than 50 per cent (47.5 per cent) for any GP and only 30.2 per cent for a female GP.[234]

4.10 Dr Sue Velovski, a General Surgeon and Member, Rural Doctors' Association of New South Wales, spoke with the committee at a public hearing. She said that she was unaware of 'clear evidence that the lack of access to general practice in rural and regional New South Wales has led directly to increased emergency presentations, except in the event of natural disasters.'[235] However, when patients cannot see a GP regional hospitals become 'backlogged … which means that patients who need to be seen acutely or picked up from an emergency trauma or with chest pain wait longer, which means physiologically they will have a poorer outcome.'[236]

Do non-urgent presentations contribute to access block?

4.11 Even though access to primary health care is a factor in ED attendance, low-acuity patients attending EDs usually do not take up beds or require admission to hospital.[237] This is why, as stated in chapter 2, some stakeholders in this inquiry argued that these patients do not contribute to ambulance ramping or access block.[238]

4.12 At a public hearing, the council's district chair, Dr Setthy Ung, told the committee that patients who deteriorate from low acuity to high acuity because they cannot access primary care present more often and are admitted more frequently, contributing to access block. He said: 'There are all these patients with chronic conditions and if they had better care—and that's something to share with the Commonwealth; better care out in the community—they would destabilise less often, need to come to hospital less often, need to be admitted less often …'[239]

4.13 Mr Scott Beaton, a Station Officer in Central West New South Wales and Vice President of the Australian Paramedics Association (New South Wales), explained how limited access to primary care can cause a patient to deteriorate and potentially contribute to access block:

> It can take … up to three weeks to get an appointment at the GP. A lot of people will say, "I'm not that sick. I will wait until I can get in to see the doctor." That could be two weeks away and they've got a bit of a chest infection and they progressively get worse to the point where they can't breathe and so they end up calling an ambulance and being presented into the hospital. That means that they are desperately unwell and they need

234 Joanne Bradbury et al, 'Actual availability of appointments at general practices in regional NSW' (2017) 46(5) Australian Family Physician 321, 324.

235 Evidence, Dr Sue Velovski, General Surgeon, Ballina and Lismore and Committee member, Rural Doctors' Association of NSW, 5 October 2022, p 49.

236 Evidence, Dr Velovski, 5 October 2022, p 52.

237 Submission 26, Professor James Mallows, p 17; Submission 33, Australian Medical Association (NSW) Ltd, p 5.

238 For example see: Submission 16, Australasian College for Emergency Medicine, p 3; Submission 20, Dr Kendall Bein, pp 6-7; Submission 29, ASMOF NSW - the Doctors' Union, p 3; Submission 33, Australian Medical Association (NSW) Ltd, pp 5-6.

239 Evidence, Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, 5 October 2022, p 5.

> to be at a bigger hospital and they take up a bed in the hospital now for a week. The ability to get in to see the doctor in an earlier time frame with some antibiotics would mean that they may never have presented to a hospital in the first place …[240]

4.14 The New South Wales Nurses and Midwives Association advised that community nursing and nurse practitioners play an important role in preventative medicine.[241]

4.15 There was wider agreement among stakeholders, though, that lack of access to primary care in the community contributes to overcrowding in EDs and puts patients' health at risk. For example, the South Western Sydney Local Health District Medical Staff Council Chairs expressed the following concerns:

- the COVID-19 pandemic meant patients with mild acute respiratory and infectious illnesses were prevented from attending their GPs
- patients with chronic and complex problems who do not see a GP can quickly become high-acuity patients presenting at EDs
- patients waiting for a long time in EDs can deteriorate thereby requiring a higher level of treatment.[242]

4.16 To help address access block, Dr Michael Bonning from the Australian Medical Association of New South Wales argued for an increase in the Medicare rebate for primary care services to help patients currently unable to afford these services. He said: 'We know that those people will then end up in emergency departments with unplanned and deteriorating health that requires more significant healthcare interventions.'[243]

Will improved access to primary care prevent presentations to the emergency department?

4.17 NSW Health cautioned against thinking that improving access to GPs and other primary care services will prevent presentations to ED alone. It strongly agreed that improving access is worthwhile in and of itself. However, as noted in the evidence from Taylor Fry above, EDs will always be better positioned to provide services such as rapid pathology, imaging and diagnostics, which facilitate fast assessment and care in medical emergencies.[244]

4.18 Taylor Fry agreed that lack of access to primary care is only one reason why low-acuity patients present to EDs. Other reasons include:

- patient-perceived urgency and complexity
- socioeconomic factors

240 Evidence, Mr Scott Beaton, Station Officer - Central West and Vice President, Australian Paramedics Association (NSW), 5 October 2022, pp 23-24.

241 Submission 31, New South Wales Nurses and Midwives' Association, p 14.

242 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 5.

243 Evidence, Dr Michael Bonning, President, Australian Medical Association NSW, 7 October 2022, p 6.

244 Submission 35, NSW Health, pp 27-28.

- patient choice
- GP advice to visit an ED
- convenience (access to radiology and imaging at no cost, in one location)
- financial cost to the patient.[245]

4.19 Professor James Mallows presented a similar argument, stating: 'The ED is indeed a one-stop-shop for multiple health services, including imaging, pathology and allied health services and has the ability to give analgesia beyond what is capable in a GP practice. EDs must be resourced for what the community expects their role is…'[246]

4.20 Lack of access to primary care can also cause delays for patients ready to be discharged. Dr Pramod Chandru, an Emergency Medicine Staff Specialist at Westmead and Nepean hospitals, gave the following hypothetical example to the committee: '… if I send someone home and I say, "Could you please see your GP in a day or two to get some follow-up for this particular reason you have come to the ED," and they tell me, "Well, it's a two-week wait to see my GP," what am I supposed to do with that information?'[247]

4.21 Dr Liz Swinburn, a Senior Emergency Physician at Royal North Shore Hospital, explained that if EDs know that patients can access primary care 'we can send [them] home knowing that they have an appointment in two days to follow up. The alternative is admitting the patient to hospital, and that could be three or four days.'[248]

4.22 The 2022 GP Workforce Report (across Australia) prepared by Deloitte found:

- with an ageing and growing population, demand for GP services is projected to increase by 38 per cent by 2032 (and by 47 per cent in our cities)
- supply of GPs will decrease by 15 per cent in cities and by 4 per cent overall
- this will result in a shortfall of 11,392 GPs by 2032, or almost 1 in 3 (28 per cent) of the GP workforce
- the main driver of this trend is workforce renewal as the general practice workforce is ageing – the proportion of GPs over the age of 65 increased from 11.6 pr cent in 2015 to 13.3 per cent in 2019.[249]

4.23 The committee was also told that the proportion of final-year students listing general practice as their first preference specialty has fallen to 15.2 per cent, the lowest since 2012.[250]

245 Submission 23, Taylor Fry Pty Ltd, p 5.

246 Submission 26, Professor James Mallows, p 17.

247 Evidence, Dr Pramod Chandru, Emergency Medicine Staff Specialist, 5 October 2022, p 40.

248 Evidence, Dr Liz Swinburn, Senior Emergency Physician, Royal North Shore Hospital, 7 October 2022, p 11.

249 Deloitte, 'General Practitioners Workforce Report 2022. Prepared for Cornerstone Health Pty Ltd', May 2022, p iii.

250 Submission 35, NSW Health, p 27.

Access to mental health services

4.24 Stakeholders in this inquiry discussed the adequacy of mental health services in New South Wales in terms of impact on ED presentations and patients' health.

Access to mental health services and access block

4.25 The committee heard evidence about inadequate funding of mental health services, both in the community and for inpatients. For example, Dr Jaqueline Huber from the Royal Australian and New Zealand College of Psychiatrists told the Committee that across Australia over the past five years the number of mental health ED presentations has increased by 15 per cent but the number of inpatient beds has gone up only by five per cent.[251]

4.26 In its submission to this inquiry, the Australian Medical Association of New South Wales said mental health patients disproportionately experience delays and access block because of a lack of support available both in the community and in EDs. The Association wrote: 'This is a particular problem in regional, rural and remote areas which have demonstrated significantly higher percentages of presentations waiting for inpatient beds and experiencing mental health access block.'[252]

4.27 Dr Velovski from the Rural Doctors' Association of New South Wales confirmed how difficult it is to access mental health services in regional areas. She said that waiting times for non-urgent mental health care were between 16 and 18 weeks prior to COVID-19 and recent fires and floods. This figure has since increased, exacerbated by a lack of access to GPs who provided care in the past. Dr Velovski added:

> … there are multiple patients in the emergency department waiting to be assessed by our psychiatric colleagues. A number of patients on every shift, quite a number of days, will self-harm or are angry and harming our staff. So it's dangerous for our staff and dangerous for the patient, and they're waiting extraordinary hours to be seen in a very crowded facility.[253]

4.28 The committee also received evidence from Ms Suzanne Melchior, a Senior Registered Nurse in the Northern Rivers region. Ms Melchior told the committee that funding cuts in her region caused the closure of a community hub that provided local mental health care. Services are now centralised in base hospitals. She explained: 'We've had to reintroduce MHEC-RAP, which is the impersonal mental health assessment over Zoom … sometimes it would freeze, and a person who was genuinely mentally unwell would not cope even with that process of admission.'[254]

4.29 Some metropolitan areas experience similar difficulties accessing mental heath services. NSW Health provided the Committee with the example of the South Western Sydney Local Health

251 Evidence, Dr Jaqueline Huber, Fellow, Royal Australian and New Zealand College of Psychiatrists, 5 October 2022, p 60.

252 Submission 33, Australian Medical Association (NSW) Ltd, p 6.

253 Evidence, Dr Velovski, 5 October 2022, pp 54-55.

254 Evidence, Ms Suzanne Melchior, Senior Registered Nurse, Northern Rivers NSW, 5 October 2022, p 55.

District where there are only two private psychiatrists who accept and manage people with an intellectual disability.[255]

4.30 In her evidence, Dr Huber discussed mental health crisis teams in hospitals that used to:

- offer home visits
- deliver medication
- provide community appointments with mental health services.

4.31 These community teams reduced the number of patients presenting to EDs with mental health issues. However, Dr Huber said that a reduction in funding for these teams caused an increase in presentations for patients with mental health issues.[256]

Suitability of emergency departments for mental health patients

4.32 The committee heard from Mr Christopher Stone, Policy and Government Relations Manager, Suicide Prevention Australia, that EDs can be distressing places that can intensify a mental health crisis. This is because EDs can be very noisy and, at times, chaotic. As well, at busy times patients are often left to themselves.[257]

4.33 At a public hearing, Miss Charlotte Gonzaga described her personal experience of being in an ED in state of high distress. She told the committee:

> … when I was there in crisis, like most days I'm assuming in the emergency department, it was just a lot of scrambling and a lot of moving about. And at the time they didn't have any mental health nurses or no-one at least that was brought to my attention nor was I brought to their attention. So I was left just waiting for five, almost six, hours with no update on what was going on. It would have absolutely made a world of difference if, even for just five minutes at the start, someone was there to sit with me and talk me through what was going on or to really just check in with me.[258]

4.34 Miss Gonzaga added:

> I've had close friends of mine in high school who have been in situations like that and have, unfortunately, just acted on those self-harm ideations ... Unfortunately, what happens when you're alone for how many hours or how many days—a lot of people, unfortunately, do act on those ideations that they go to the hospital for help with.[259]

4.35 The Secretary of NSW Health, Ms Susan Pearce, acknowledged that EDs can be difficult places for people with mental health issues. She referred to the 15 'Safe Havens' around New South

255 Submission 35, NSW Health, p 29.

256 Evidence, Dr Huber, 5 October 2022, p 60.

257 Evidence, Mr Christopher Stone, Policy and Government Relations Manager, Suicide Prevention Australia, 5 October 2022, p 58.

258 Evidence, Miss Charlotte Gonzaga, Lived experience speaker, Batyr, 5 October 2022, p 61.

259 Evidence, Miss Gonzaga, 5 October 2022, p 62.

Wales that are an alternative to EDs. Ms Pearce also told the committee that New South Wales EDs have the highest proportion of mental health patients seen on time in Australia.[260]

4.36 Suicide Prevention Australia spoke about the need for alternatives to EDs, such as Safe Havens. It stated in its submission: 'Providing alternatives for those in mental or suicidal crisis, especially young people, will not only divert more people from ED, reducing the need for ramping, it will also provide an environment that is better able to address their needs.'[261]

4.37 Dr Huber said that in her LHD mental health peer workers, who she considers to be 'extraordinary individuals', go into the ED to tell people about the closest Safe Haven. Dr Huber said that Safe Havens are 'just fantastic, wonderful and do a really good job but … are not universally accessible and are generally not accessible 24 hours.'[262]

4.38 Dr Huber also spoke positively with the committee about hospitals in New South Wales trialling programs that have areas of EDs staffed by mental health nurses and where patients have access to a crisis unit and a toxicology unit.[263]

Access to aged care/NDIS services

4.39 Several stakeholders in this Inquiry identified features of residential aged care facilities (RACFs) and NDIS services as a contributing factor to ambulance ramping, ED overcrowding and access block.[264] Similar to the discussion above on primary health care, this is because of patients not receiving treatment in the community or facing delays when they are ready to be discharged from hospital.

Data on aged care residents and NDIS participants presenting to emergency departments

4.40 NSW Health informed the committee that as of 3 August 2022 there were:

- 519 RACF inpatients in NSW Health facilities with 327 (63 per cent) exceeding their estimated date of discharge
- 557 NDIS inpatients with 293 (53 per cent) exceeding their estimated date of discharge.[265]

4.41 For the NDIS, the estimated cost of total bed days past estimated date of discharge for regional areas is $14,591,500 and for metropolitan areas is $18,255,600.[266]

260 Evidence, Ms Susan Pearce, Secretary, NSW Health, 7 October 2022, p 39.

261 Submission 18, Suicide Prevention Australia, p 2.

262 Evidence, Dr Huber, 5 October 2022, pp 59; 60.

263 Evidence, Dr Huber, 5 October 2022, p 59.

264 For example see: Submission 10, Name Suppressed, p 2; Submission 13, Name Suppressed, p 3; Submission 28, Australasian College of Paramedicine, p 28; Submission 29, ASMOF NSW - the Doctors' Union, pp 3-4; Submission 33, Australian Medical Association (NSW) Ltd, pp 6-7.

265 Submission 35, NSW Health, p 28.

266 Submission 35, NSW Health, p 29.

4.42 Ms Pearce, the Secretary of NSW Health, acknowledged that there is a large number of people waiting to be discharged. However, she stressed that 'it's our job to care for them. To be clear, I don't want that to be read as we're denigrating those people or being disrespectful or uncaring. It's just that they've been medically cleared for discharge and we're unable to discharge them.'[267]

4.43 In its submission, the Health Services Union (NSW/ACT/Qld) spoke specifically about the Illawarra. It said that as of 1 March 2022, 8.6 per cent of hospital beds were occupied by aged care residents, an increase of 3 per cent from 1 March 2020. Over that same two-year period, 210 residential aged care beds had been shut in the region.[268]

4.44 The New South Wales Nurses and Midwives Association reported that 'potentially avoidable presentations from aged care facilities occur on a daily basis', the most common reasons being:

- falls
- palliative care
- behaviour management
- catheterisation or re-catheterisation.[269]

4.45 Other evidence received by the committee suggests that some patients' end-of-life choices stating that they do not want to go to hospital have been ignored. As well as being against the patients' wishes, this increases the number of presentations from RACFs.[270]

4.46 The Australian Medical Association provided the following estimates for the year to June 2021:

- potentially preventable hospitalisations from nursing homes: 27,569 hospitalisations or 159,693 patient days
- non-admitted ED presentations from nursing homes: 49,300 presentations
- hospital re-presentations from nursing homes: 18,800 re-presentations
- people waiting in hospital for a place in a nursing home: 232,000 patient days.[271]

Clinical expertise in aged care settings

4.47 The problems in relation to aged care residents presenting to EDs arise because of a combination of two main factors: where registered nurses (RNs) at RACFs do not have the skills to deal with relatively minor issues and therefore ring 000; where RNs are not onsite 24 hours a day, seven days a week, meaning problems arising out-of-hours require an ambulance to take the patient to an ED.

267 Evidence, Ms Pearce, Secretary, NSW Health, 7 October 2022, p 37.

268 Submission 34, Health Services Union (NSW/ACT/Qld), p 7.

269 Submission 31, New South Wales Nurses and Midwives' Association, p 15.

270 Evidence, Ms Sophie Dyson Director, Taylor Fry Pty Ltd, 7 October 2022, p 30; Answers to questions on notice, Ms Sophie Dyson, Director, Taylor Fry, 24 October 2022, p 2.

271 Australian Medical Association. Putting health care back into aged care. Canberra: AMA, 2021 p 10.

4.48 The Australian Medical Association of New South Wales raised the issue of RACFs sending patients to EDs because they do not understand advanced care directives. In its submission to this Inquiry, it said: 'There must be better consultation regarding those who should not be sent to hospital between aged care staff and paramedics, and this should include access to clear and identifiable information regarding advance care directives for aged care residents.'[272]

4.49 Mr Beaton, a Station Officer in Central West New South Wales and Vice President of the Australian Paramedics Association (New South Wales), said most RACFs in regional New South Wales will only have an RN on duty during business hours. Speaking specifically about end-of-life plans, Mr Beaton that 'the staff only have certain a skill set, so their fallback is to call an ambulance to then assess this patient.'[273]

4.50 The New South Wales Nurses and Midwives Association said that a combination of an increased need for palliative care and lack of clinical expertise in RACFs has seen outreach programs, such as Hospital in the Home (HITH), delivered across New South Wales. The Association expressed concern about to cost to LHDs of funding outreach programs. However, it believes these programs are efficient ways of avoiding presentations and 'a better option for many, given the poor health outcomes associated with hospitalising older people.'[274]

4.51 The South Western Sydney Local Health District Medical Staff Council Chairs submitted: 'Adequately resourced and coordinated Community Outreach Geriatric Support (COGS) services for nursing homes may improve ED and hospital avoidance.'[275]

4.52 Dr Bonning from the Australian Medical Association of New South Wales told the committee that elderly patients with complex needs are best treated 'in their own home or in an environment that is familiar to them. That's better for their long-term care and health.'[276]

4.53 Ms Sophie Dyson, Director at Taylor Fry, listed the advantages of RACFs over hospital care for elderly patients, including:

- infrastructure
- hospital beds
- nursing staff
- outreach programs.

4.54 As such, Ms Dyson concluded that a lot of tools are already in place for RACFs to help decrease demand on ambulances and hospitals. She said that 'actually making a decision about what should and shouldn't be transferred to hospital and delivering more of that care within the aged-

272 Submission 33, Australian Medical Association (NSW) Ltd, p 7.

273 Evidence, Mr Beaton, 5 October 2022, p 18.

274 Submission 31, New South Wales Nurses and Midwives' Association, p 16. Other outreach programs discussed in the submission are the GRACE program in Northern Sydney LHD and South Eastern Sydney LHD Geriatric Flying Squad and REAP programs. An evaluation of the Geriatric Flying Squad revealed $1.4m potential cost savings, with the program costing the LHD $400,000 annually to run.

275 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 6.

276 Evidence, Dr Bonning, 7 October 2022, p 4.

care environment would free up, I think, the kind of breathing space that you're looking for, some of that capacity.'[277]

Delays discharging aged care residents

4.55 Stakeholders also identified a contributing factor to access block being when aged care residents face delays being discharged from hospital because they don't have an adequate facility to return to.[278] Mr John Bruning, Chief Executive Officer of the Australasian College of Medicine discussed this issue with the committee at a public hearing. He explained that 'you get to the point where you go, "Can they safely go back? Can they be cared for appropriately back in the facility?" If that answer is no, then that's it; they are staying.'[279]

4.56 The New South Wales Nurses and Midwives Association told the committee that in research it conducted lack of transport was the most common reason for delayed discharge for aged care residents. Other reasons include:

- refusal by a relative to have the person returned to a facility
- insufficient staffing levels at the facility
- lack of trained staff at the facility, including the absence of an RN.[280]

4.57 In its submission, the South Western Sydney Local Health District Medical Staff Council Chairs raised the issue of long delays accessing Aged Care Assessment Team assessments for patients. It wrote: 'The SWSLHD-MSC wonders why the State acute hospital system should have to shoulder the burden of the deficiency of ACAT.'[281]

Delays discharging NDIS participants

4.58 The committee also considered people with disabilities and the NDIS. NSW Health told the committee that people with disabilities have a high use of emergency and acute care services. Reasons for this include difficulty accessing GPs in the community and that some people need to be sedated for transport and minor procedures, such as blood tests or dental care. Hospital demand is also influenced by them being seen as 'providers of last resort' if people lose their disability supports or becomes homeless. A more recent factor is the number of new disability providers with limited experience supporting people with complex needs. Their lack of experience means these providers frequently direct their clients to EDs.[282]

277 Evidence, Ms Sophie Dyson Director, Taylor Fry Pty Ltd, 7 October 2022, p 30.

278 For example see: Submission 20, Dr Kendall Bein, p 8; Evidence, Dr Velovski, 5 October 2022, p 49.

279 Evidence, Mr John Bruning, Chief Executive Officer, Australasian College of Paramedicine, 5 October 2022, p 23.

280 Submission 31, New South Wales Nurses and Midwives' Association, p 15

281 Submission 24, South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, p 6.

282 Submission 35, NSW Health, p 29.

4.59 Stakeholders in this inquiry argued that problems with the NDIS are contributing to access block through creating delays in discharge. Dr Bonning from the Australian Medical Association of New South Wales quoted data revealing that nationally around 1,400 NDIS clients wait an average of 160 days before they are discharged from hospital because of a lack of a suitable home.[283]

4.60 DEC Housing Limited also referred to this data, adding: 'This will be significantly more if those who either have not yet obtained NDIS support, or are not eligible for NDIS support, still require supported living accommodation.'[284]

Current measures being undertaken by NSW Health

4.61 This section examines the effectiveness of current measures by NSW Health in relation to primary care to address ambulance ramping, access block and emergency department delays.

Measures to address coordination with aged care facilities/NDIS

4.62 The committee notes that the Commonwealth is responsible for aged care and the NDIS. Regarding aged care, the Australian Government's aged care reforms passed the Senate on 27 October 2022. As of 1 July 2023, aged care homes must have an RN onsite 24 hours a day, seven days a week.

4.63 Further, in October 2022, the Minister for the NDIS, the Hon Bill Shorten MP, announced that 54 NDIS Specialised Hospital Discharge Planners will begin working in hospitals across the country. Their aim is to 'speed up discharge by working with participants throughout their hospital journey, using increased delegation and decision making powers to approve higher plan values at a local level where needed.'[285]

4.64 Ms Pearce told the committee that the states and territories are having 'productive discussions' with the Commonwealth on these issues. Ms Pearce said:

> There are various groups that are meeting at a State and Commonwealth level to talk about that very issue, and the Commonwealth Government has been quite vocal. Minister Shorten attended a Health Ministers' meeting not long ago to talk very clearly about the improvements that he would like to see in the NDIS, and we're very encouraged by that, and certainly we're having very active discussions with the Commonwealth about primary care.[286]

4.65 Additionally, NSW Health informed the committee that it is investigating different out-of-hospital care models 'to facilitate more timely discharge of people with a disability.'[287]

283 Evidence, Dr Bonning, 7 October 2022, p 2.

284 Submission 27, DEC Housing Limited, p 1.

285 The Hon. Bill Shorten MP, 'Getting NDIS participants home from hospital', Media Release, 20 October 2022.

286 Evidence, Ms Pearce, 7 October 2022, p 37

287 Submission 35, NSW Health, p 29.

Integrated care

4.66 To deliver better outcomes for patients and reduce pressure on hospital services NSW Health is integrating care both across its own services through the Integrated Care Program, as well as across regions in partnership with primary care and other providers through the new Collaborative Commissioning model. Examples include:

- integrated care programs
- residential aged care
- vulnerable families
- paediatric network
- specialist outreach to primary care
- Planned Care for Better Health
- ED to Community
- referral pathways.[288]

4.67 The Australian Medical Association of New South Wales told the committee: 'AMA (NSW) supports important measures taken by NSW Health to address the fragmented nature of our health system through the NSW Integrated Care Strategy.'[289]

4.68 Measures to improve the integration of care are outlined below.

Virtual Care Strategy

4.69 Virtual care safely connects patients with health professionals using technology such as telephones, video conferencing and remote monitoring. In relation to this inquiry, benefits include to:

- reduce potentially preventable hospitalisations
- reduce length of hospital stays
- improve system integration between primary care and acute care.[290]

HealthDirect and triage to ease pressure on EDs

4.70 NSW Health funds the NSW Ambulance Secondary Triage to support the management of emergency resources by ensuring the availability of ambulances for the most urgent situations. Callers who dial 000 and do not need an ambulance are transferred to the HealthDirect helpline, a 24-hour, seven day a week telephone-based nurse triage and advice service.[291]

288 Submission 35, NSW Health, p 36.

289 Submission 33, Australian Medical Association (NSW) Ltd, p 11.

290 Submission 35, NSW Health, p 37.

291 Submission 35, NSW Health, p 45.

4.71 The Australasian College of Paramedicine argued that secondary triage services 'should be expanded further. This would successfully manage to divert more patients away from ambulances and EDs.'[292]

Virtual Clinical Care Centre (VCCC)

4.72 The primary function of a VCCC is to provide secondary triage of low-acuity patients. In September 2021, NSW Ambulance implemented a COVID VCCC. In June 2022, the NSW Government announced an investment in VCCCs of $1.76 billion over four years. Virtual care by a VCCC specialist clinician 'ensures that patients with lower acuity needs who can safely remain in the community do so thereby preserving frontline paramedics for life threatening emergencies.'[293]

4.73 Mr David Waters, Chief Executive, The Council of Ambulance Authorities, said that the VCCC is 'a great example of how we can manage patient flow, provide solutions for patients in their homes without them having to be transported or provide some forms of referral service.'[294]

4.74 According to Mr Dominic Morgan, the Commissioner and Chief Executive of NSW Ambulance, in 12 months:

- the VCCC diverted around 13,500 patients from ambulances
- NSW Ambulance referred around 67,000 patients to HealthDirect.[295]

Aged care

4.75 According to NSW Health, the number of people who could be discharged to an RACF but remain in hospital has doubled since 2020.[296] Measures to improve discharge to RACFs are outlined below.

Secondary Triage for Residential Aged Care Facilities

4.76 In March 2020, NSW Health and NSW Ambulance implemented the Secondary Triage for Residential Aged Care Facilities initiative. This came about during the COVID-19 pandemic to reduce unnecessary transfers from RACFs to EDs and/or hospitals.

4.77 NSW Health told the committee that between June 2020 and June 2021, NSW Ambulance received 106,254 calls from RACFs of which 47,833 were classified as low acuity calls (45 per cent). Of these, 12 per cent (5,885) were managed by the Secondary Triage process with 57 per cent (3,343) of residents receiving their care in residence, with no transfer to hospital required.[297]

292 Submission 28, Australasian College of Paramedicine, p 6.

293 Submission 35, NSW Health, p 38.

294 Evidence, Mr David Waters, Chief Executive, The Council of Ambulance Authorities Inc, 5 October 2022, p 30.

295 Evidence, Mr Dominic Morgan, Commissioner and Chief Executive, New South Wales Ambulance, 7 October 2022, p 45.

296 Submission 35, NSW Health, p 30.

297 Submission 35, NSW Health, p 49.

The Transitional Aged Care Program

4.78 All local health districts and the St Vincent's Health Network deliver Transitional Aged Care Program (TACP) services to support timely discharge of aged care patients. The TACP started in 2005-06 and is jointly funded by the Australian Government (75 per cent) and NSW Government (25 per cent), with total funding of around $127 million in 2020-21.[298]

Disability sector

4.79 All states and territories are working with the Commonwealth to reduce unnecessary hospital admission and discharge delays for people with disability. There is currently no nationally agreed minimum data set to report on the number of NDIS participants who experience hospital discharge delays. However, according to NSW Health, this is a 'priority for action outlined in recent communications from the Minister for Health and Disability Reform Minister Meetings.'[299]

4.80 Much of this work occurring in New South Wales is in cooperation with strategies such as Integrated Care.[300]

Outpatients

4.81 NSW Health described outpatient services as 'a critical interface between inpatient care and primary care systems, and an important ongoing component in a patient's care pathway. NSW Health offers over 7,000 outpatient clinics and 17 million non-admitted episodes of care per year.'[301]

4.82 Other stakeholders described public outpatient services as 'a really great way of preventing admissions'[302] and a 'significant benefit to the community.'[303]

Leading Better Value Care

4.83 Every LHD across New South Wales is implementing 13 LBVC clinical initiatives. The 2019-20 results for the three early implemented and scaled initiatives (Osteoporotic Refracture Prevention, Osteoarthritis Chronic Care Program, and High Risk Foot Services) indicate that as provision of patient centred care in outpatient settings increased, the demand for hospitalisation overall flattened against business as usual projections.[304]

298 Submission 35, NSW Health, p 49.

299 Submission 35, NSW Health, p 43.

300 Submission 35, NSW Health, p 44.

301 Submission 35, NSW Health, p 40.

302 Evidence, Dr Swinburn, 7 October 2022, p 10.

303 Evidence, Dr Bonning, 7 October 2022, p 7.

304 Submission 35, NSW Health, p 35.

Reducing ED visits and providing care to people in the community and their homes

4.84 In 2020-21, NSW Health launched Planned Care for Better Health (PCBH), one of the Integrated Care 'flagship' programs. PCBH aims to identify improved care for people at risk of hospitalisation.

4.85 In 2022, NSW Health will launch the ED to Community initiative, to support patients who have frequently presented to an ED, as identified through an algorithm. It is expected to go live in late 2022.

4.86 NSW Health informed the committee that there have been 640,000 instances of low acuity ED attendances and bed days avoided collectively as a result of the PCBH program and other integrated care initiatives over the past three years.[305]

4.87 Other outpatient services listed in the NSW Health submission to this inquiry include:

- Health GP Deputising Service
- Out of Hospital Care Program
- Hospital in the Home
- rapid access clinics.[306]

Committee comment

4.88 This inquiry demonstrated that the 'fractured' nature of health funding in Australia, and overlapping responsibilities among the different levels of government, is problematic. This is evident in all stages of a patient's journey: prior to presenting to an ED; while being treated; and at the time of discharge.

4.89 The committee heard that expectations of how a health system should function are slowly changing, with an increased emphasis on delivering health in place. As yet though, the required structural change and investment in community care do not match these changing expectations.

4.90 EDs are designed to treat acute patients. However, they are increasingly called upon to provide longer-term care. Access to GPs and other primary care providers is one problem. While 'GP-type' patients do not take up many resources, they can contribute to overcrowding in EDs. Worse, patients not treated in the community when they first develop symptoms may present later in hospitals with more complex problems.

4.91 The committee is concerned to hear that the same problem is occurring with NDIS clients and RACF residents. Both low-acuity and high-acuity patients are presenting in EDs because they cannot be treated in place.

4.92 Equally, the evidence showed that some patients ready to be discharged are kept in hospital because they do not have access to a suitable primary care provider when they leave hospital.

305 Submission 35, NSW Health, pp 36-37.

306 Submission 35, NSW Health, pp 38-40.

Further delays come from patients not being able to access NDIS services or not having suitably staffed RACFs available to them.

4.93 We underscore that solutions to patient flow must keep the patient first and foremost in mind. That is, solutions should not only reduce pressure on ambulances and hospitals to meet a KPI or other measurement. Nor should they 'hide' the problem by shifting it from one area to another. Solutions must ensure patients are receiving the best healthcare at the best time and in the best place.

4.94 It is clear that federal funding responsibilities, including access to primary care services, aged care and the NDIS, have a significant impact on patient flow. The committee notes that the NSW Government is working with the Commonwealth to improve community care services that offer an alternative to hospital care. We urge the government to continue this work. We recommend that the NSW Government continue to engage with the Commonwealth Government at the highest level on access to GP services, and admission and discharge of aged care residents and NDIS participants.

Recommendation 10

That the NSW Government continue to engage with the Commonwealth Government at a ministerial level on out of hospital care alternatives to improve patient flow, including access to GP services, and admission and discharge of aged care residents and NDIS participants.

4.95 Access to community mental health services was a feature in this inquiry, in particular for young people. NSW Health acknowledges that EDs are sub-optimal locations for people experiencing mental health issues. The NSW Government should continue to support alternatives to hospital admission, such as Safe Havens, as well embedding mental health specialists in EDs. The committee recommends that the NSW Government improve access to Safe Havens and consider how EDs can be made more appropriate spaces for mental health patients.

Recommendation 11

That the NSW Government improve access to community mental health services, in particular for young people, such as through the Safe Havens program. It should also consider ways of making emergency departments more appropriate spaces for mental health patients, including improving access to mental health specialists within emergency departments.

4.96 The committee acknowledges that ambulance ramping, ED overcrowding and access block are complex, multifaceted problems, and are not going to be solved overnight. Many of the recommendations outlined in this report will take some time to implement and to take effect. Nonetheless, the current situation across hospitals in New South Wales is acute and is putting patient and staff safety at risk – so it is important to consider immediate, interim solutions as well. These immediate solutions will differ between hospitals and location, and require bespoke plans that consider the needs of each hospital rather than a one size fits all solution. The committee therefore recommends that the NSW Government work with hospitals to develop interim solutions on a hospital-by-hospital basis to assist with ambulance ramping, ED

overcrowding and access block, to provide short-term relief while long term solutions are being implemented.

Recommendation 12

That the NSW Government work with hospitals to develop interim solutions on a hospital-by-hospital basis to assist with ambulance ramping, emergency department overcrowding and access block, to provide short-term relief while long-term solutions are being implemented.

Appendix 1 Submissions

No.	Author
1	Dr Luke Dawson, A/Prof Dion Stub and Dr Ziad Nehme
2	Name suppressed
3	Name suppressed
4	Name suppressed
5	Ms Bridgit Akmacic
6	Miss Alex Powell
7	Mrs Robyn Loomes
8	Name suppressed
9	Name suppressed
10	Name suppressed
11	Mrs Jacqui Buckley
12	Mrs Suzanne Melchior
13	Name suppressed
14	Royal Australian and New Zealand College of Psychiatrists
15	The Society of Hospital Pharmacists of Australia (SHPA)
16	Australasian College for Emergency Medicine
17	Western Sydney Primary Health Network (WentWest)
18	Suicide Prevention Australia
19	Australian Paramedics Association (NSW)
20	Dr Kendall Bein
21	Dr Pramod Chandru and Dr James Tadros
22	Professor Graham Reece
23	Taylor Fry Pty Ltd
24	South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs
25	Professor Ray Bange OAM
26	Professor James Mallows
27	DEC Housing Limited
28	Australasian College of Paramedicine
29	ASMOF NSW - the Doctors' Union
30	Confidential
31	New South Wales Nurses and Midwives' Association

No.	Author
32	Rural Doctors' Association of New South Wales
33	Australian Medical Association (NSW) Ltd
34	Health Services Union (HSU)
35	NSW Health

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Wednesday 5 October 2022 **Macquarie Room** **Parliament House, Sydney**	Dr Clare Skinner	President, Australasian College for Emergency Medicine
	Mr James Gray	Manager – Policy and Advocacy, Australasian College for Emergency Medicine
	Mr John Bruning	Chief Executive Officer, Australasian College of Paramedicine
	Ms Michelle Murphy	Advocacy and Government Relations Lead, Australasian College of Paramedicine
	Mr Chris Kastelan	Paramedic on Central Coast and President, Australian Paramedics Association (NSW)
	Mr Scott Beaton	Station Officer - Central West and Vice President, Australian Paramedics Association (NSW)
	Mr David Waters	Chief Executive, The Council of Ambulance Authorities Inc
	Associate Professor Ray Bange, OAM	Private individual
	Dr Pramod Chandru	Emergency Medicine Staff Specialist
	Dr James Tadros	Emergency Medicine Staff Specialist
	Dr Setthy Ung	District Chair, South Western Sydney Local Health District Medical Staff Executive Council
	Mr Gerard Hayes	Secretary, Health Services Union (NSW/ACT/QLD)
	Ms Lauren Hutchins	Assistant Secretary, Health Services Union (NSW/ACT/QLD)

Date	Name	Position and Organisation
	Ms Shaye Candish	General Secretary, NSW Nurses and Midwives' Association
	Ms Kelly Falconer	Registered Nurse and member, NSW Nurses and Midwives' Association
	Dr Sue Velovski	General Surgeon, Ballina and Lismore and Committee member, Rural Doctors' Association of NSW
	Ms Suzanne Melchior	Senior Registered Nurse, Northern Rivers NSW
	Dr Jaqueline Huber	Fellow, Royal Australian and New Zealand College of Psychiatrists
	Mr Christopher Stone	Policy and Government Relations Manager, Suicide Prevention Australia
	Miss Charlotte Gonzaga	Lived experience speaker, Batyr
Friday 7 October 2022 **Room 814-815** **Parliament House, Sydney**	Dr Michael Bonning	President, Australian Medical Association NSW
	Dr Tony Sara	President, Australian Salaried Medical Officers' Federation
	Dr Liz Swinburn	Senior Emergency Physician, Royal North Shore Hospital
	Mr Jerry Yik	Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia
	Dr Jonathan Penm	Chair, NSW Branch Committee, The Society of Hospital Pharmacists of Australia
	Dr Kendall Bein	Emergency Department Staff Specialist
	Associate Professor James Mallows	Staff Specialist Emergency Physician and Director Emergency Medicine Research, Nepean Hospital

Date	Name	Position and Organisation
	Ms Sophie Dyson	Director, Taylor Fry Pty Ltd
	Associate Professor Graham Reece	Intensive Care Specialist and Director, Intensive Care, Blacktown Hospital
	Ms Susan Pearce	Secretary, NSW Health
	Mr Matthew Daly	Deputy Secretary, Patient Experience and System Performance, NSW Health
	Dr Dominic Morgan	Commissioner and Chief Executive, NSW Ambulance

Appendix 3 Minutes

Minutes no. 63
Tuesday 26 July 2022
Portfolio Committee No. 2 – Health
Room 1043, Parliament House, Sydney at 2.31 pm

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato (via WebEx)
Mr Barrett (substituting for Mr Fang, via WebEx)
Ms Faehrmann (via WebEx)
Mr Secord

2. Apologies
Mr Fang
Mr Rath

3. Correspondence
The committee noted the following items of correspondence:

Received

- 21 July 2022 – Letter from Mr Donnelly, Ms Faehrmann and Mr Secord requesting a meeting of Portfolio Committee No. 2 to consider a proposed self-reference into the impact that ambulance ramping and access block is having on the operation of hospital emergency departments in New South Wales.

4. Consideration of terms of reference
The chair noted the following self-reference proposed by himself, Mr Secord and Ms Faehrmann as previously circulated:

That Portfolio Committee No. 2-Health inquire into and report on the impact that ambulance ramping and access block is having on the operation of hospital emergency departments in New South Wales, and in particular:

(a) The causes of ambulance ramping, access block and emergency department delays;

(b) The effects that ambulance ramping and access block has on the ability and capacity of emergency departments to perform their function;

(c) The impact that access to GPs and primary health services has on emergency department presentations and delays;

(d) The impact that availability and access to aged care and disability services has on emergency department presentations and delays;

(e) How ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff;

(f) The effectiveness of current measures being taken by NSW Health to address ambulance ramping, access block and emergency department delays;

(g) Drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider to address the impact of ambulance ramping, access block and emergency department delays; and

(h) Any other related matters.

Resolved, on the motion of Mr Secord: That the committee adopt the terms of reference.

5. Conduct of the inquiry into the impact that ambulance ramping and access block is having on the operation of hospital emergency departments in New South Wales

5.1 Proposed timeline

Resolved, on the motion of Mr Secord: That the committee adopt the following timeline for the administration of the inquiry:

- Submissions close – Sunday 11 September 2022 (six weeks)
- Hearings – Wednesday 5, Thursday 6 or Friday 7 October
- Report – deliberative in week of 5 December, tabling by 14 December 2022

5.2 Stakeholder list

Resolved, on the motion of Ms Hurst: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

5.3 Approach to submissions

The committee considered adopting the following approach to processing submissions, developed during recent inquiries with a large volume of short individual submissions.

Resolved, on the motion of Mr Amato: That, to enable significant efficiencies for members and the secretariat while maintaining the integrity of how submissions are treated, in the event that 200 or more individual submissions are received, the committee adopt the following approach to processing short submissions:

- All submissions from individuals 250 words or less in length will:
  - have an individual submission number, and be published with the author's name or as name suppressed, or kept confidential, according to the author's request
  - be reviewed by the secretariat for adverse mention and sensitive/identifying information, in accordance with practice
  - be channelled into one single document to be published on the inquiry website
- All other submissions will be processed and published as normal.

5.4 Advertising

All inquiries are advertised via Twitter, Facebook, stakeholder emails and a media release distributed to all media outlets in New South Wales.

It is no longer standard practice to advertise in the print media. The committee should pass a resolution if it wishes to do so.

6. Adjournment

The committee adjourned at 2.45 pm until Thursday 1 September 2022, Parliament House (public hearing – Budget Estimates)

Madeleine Foley
Committee Clerk

Minutes no. 64
Thursday 11 August 2022
Portfolio Committee No. 2 – Health
Members' Lounge, Parliament House, Sydney at 2.31 pm

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Mr Rath
Mr Secord

2. Minutes
Resolved, on the motion of Ms Faehrmann: That draft minutes no. 61 and 63 be confirmed.

3. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales
The Parliamentary Research Service is setting up a new model that uses external subject-matter experts to increase the availability of independent research and advice to Parliament. The committee considered whether to engage an external expert to deliver a verbal briefing early on in the inquiry, before hearings are held, to brief the committee on background and key issues and inform questioning of witnesses. The committee also discussed the potential to draw on the expert later in the process, to fill any gaps in the evidence received by the committee.

Resolved, on the motion of Mr Secord: That the committee:

- submit any further questions on the nature of the proposed engagement by COB Tuesday 16 August 2022, and subject to the satisfactory resolution of any questions, authorise the Parliamentary Research Service to engage an external expert to assist the committee, in particular to brief the committee ahead of the hearings
- have the power to approve the expert identified by the Parliamentary Research Service
- hold the pre-hearing briefing on Monday 19 September, 10 am-12 pm, subject to confirming members' availability by members.

4. Adjournment
The committee adjourned at 2.55pm until Thursday 1 September 2022, Parliament House (public hearing – Budget Estimates)

Madeleine Foley
Committee Clerk

Minutes no. 67
19 September 2022
Portfolio Committee 2
Room 1043, Parliament House, Sydney at 10 am

1. Members present
Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair* (from 10.24 am)
Mr Amato (until 11.40 am)
Ms Faehrmann
Ms MacDonald (until 11.07 am)
Mr Secord

2. Apologies
Mr Fang

3. Previous minutes

Resolved, on the motion of Ms Faehrmann: That draft minutes no. 64 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 2 August 2022 – Letter from the Hon Bronnie Taylor MLC, Minister for Women, Minister for Regional Health, Minster for Mental Health, to the Chair, in regard to recommendation 23, the palliative care taskforce, in the Health outcomes and access to health and hospital services in rural, regional and remote New South Wales report *(attached)*
- 9 August 2022 – Email from Ms Meredith Williams, Policy & Research Officer, National Rural Health Alliance to the committee declining invitation to make a submission to the inquiry *(attached)*
- 18 August 2022 – Letter from Senator the Hon Anthony Chisholm, Assistant Minister for Education, Assistant Minister for Regional Development, to the Chair, regarding the Broken Hill Airport *(attached)*
- 1 September 2022 – Email from Ms Sue Sackar, Executive Assistant, LGNSW to the secretariat declining invitation to make a submission to the inquiry *(attached)*
- 6 September 2022 – Email from Dan Newlan, Chief of Staff, Office of The Hon. Bronnie Taylor MLC, to the Chair, seeking a copy of the letter (referred to above, dated 18 August 2022) from the Commonwealth Government regarding the Broken Hill Airport (*attached*)

Resolved, on the motion of Mr Secord: That the committee authorise the secretariat to distribute the correspondence from:

- the Hon Bronnie Taylor MLC to Ms Cowie, Chief Executive Officer, Australian College of Rural & Remote Medicine
- Senator the Hon Anthony Chisholm to:
    - Mr Roy Butler MP, Member for Barwon
    - Cr Tom Kennedy, Mayor, Broken Hill Council; and
    - Mr Dan Newlan, Chief of Staff, Office of The Hon. Bronnie Taylor MLC

5. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

5.1 Public Submission

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 1, 5-7, 11-12, 14-18 and 20-29.

5.2 Partially confidential submissions (name suppressed)

The committee noted that the following submission was partially published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos 2-4, 8-10 and 13.

Resolved, on the motion of Mr Secord: That the committee keep the following information confidential, as per the requests of the authors: names and/or identifying and sensitive information in submissions nos 2-4, 8-10 and 13

5.3 Partially confidential submission (sensitive information)

Resolved, on the motion of Ms MacDonald: That the committee keep the following information confidential, as per the request of the author: sensitive information in submissions no 19.

5.4 Briefing by external expert

The committee was briefed by Professor Paul Middleton, the external subject matter expert engaged by the Parliamentary Research Service and previously approved by the committee via email.

6. Adjournment

The committee adjourned at 12.00 pm, until Wednesday 5 October 2022, Macquarie Room, Parliament House (public hearing for the ambulance ramping inquiry)

Madeleine Foley
Committee Clerk

Minutes no. 68
Wednesday 5 October 2022
Portfolio Committee No. 2 – Health
Macquarie Room, Parliament House, 9.18 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Faehrmann
Mr Fang
Ms Jackson (substituting for Mr Secord)
Ms MacDonald

2. Previous minutes

Resolved, on the motion of Mr Amato: That draft minutes no.67 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 28 September 2022 – Email from Vicky Powell, Executive Assistant to the Chief Executive Officer, Western Sydney Primary Health Care (WentWest), to the secretariat, advising that Mr Ray Messom, Chief Executive Officer, will not be able to attend the public forum to be held on 7 October 2022, but would be happy to assist at a future date.
- 29 September 2022 – Email from Ciahn Pretzel, Opposition Whip's Office to the secretariat, advising that the Hon. Rose Jackson will be substituting for the Hon. Walt Secord for the hearing on 5 October 2022.
- 30 September 2022 - Email from Ciahn Pretzel, Opposition Whip's Office to the secretariat, advising that the Hon. Mark Buttigieg will be substituting for the Hon. Walt Secord for the hearing on 7 October 2022.

Sent

- 26 September 2022 – Email from the secretariat to Ms Marita Cowie, Chief Executive Officer, Australian College of Rural & Remote Medicine, providing a copy of a letter from the Minister for Regional Health regarding recommendation 23 of the rural health inquiry report.
- 26 September 2022 – Email from the secretariat to Mr Roy Butler MP, Member for Barwon, providing a copy of a letter from The Hon Anthony Chisholm regarding the Broken Hill Airport.
- 26 September 2022 – Email from the secretariat to Cr Tom Kennedy, Mayor, Broken Hill City Council, providing a copy of a letter from the Hon Anthony Chisholm regarding the Broken Hill Airport.
- 26 September 2022 – Email from the secretariat to Mr Daniel Newlan, Chief of Staff, Office of The Hon Bronnie Taylor MLC, providing a copy of a letter from the Hon Anthony Chisholm regarding the Broken Hill Airport.

4. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

4.1 Public submissions

The following submissions will be published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 31-35.

4.2 Allocation of questioning

The committee noted that the resolution appointing the committee provides that 'the sequence of questions to be asked at hearings alternate between opposition, crossbench and government members, in that order, with equal time allocated to each'.

The committee followed this resolution for the duration of the inquiry.

4.3 Recording of hearings

Resolved, on the motion of Mr Amato: That the committee agree to record all hearings for the inquiry, and that these recordings be placed on Parliament's YouTube channel as soon as practicable after the hearings.

4.4 Public hearing

Witnesses, the public and media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Dr Clare Skinner, President, Australasian College for Emergency Medicine
- Mr James Gray, Manager – Policy and Advocacy, Australasian College for Emergency Medicine.

Dr Skinner tendered the following document:

- Report, 'Access block: A review of potential solutions', Sax Institute, September 2022.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and admitted:

- Mr John Bruning, Chief Executive Officer, Australasian College of Paramedicine
- Ms Michelle Murphy, Advocacy and Government Relations Lead, Australasian College of Paramedicine
- Mr Chris Kastelan, Paramedic on Central Coast and President, Australian Paramedics Association (NSW)
- Mr Scott Beaton, Station Officer - Central West and Vice President, Australian Paramedics Association (NSW).

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:

- Mr David Waters, Chief Executive, The Council of Ambulance Authorities Inc
- Associate Professor Ray Bange, OAM, Private individual.

Associate Professor Bange tendered the following document:

- Report, 'The ANZSCO anomalies: An examination of the Australian and New Zealand standard classification of occupations (ANZCO) for paramedicine', Ray Bange OAM, August 2022.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:

- Dr Pramod Chandru, Emergency Medicine Staff Specialist
- Dr James Tadros, Emergency Medicine Staff Specialist
- Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:
- Mr Gerard Hayes, Secretary, Health Services Union (NSW/ACT/QLD)
- Ms Lauren Hutchins, Assistant Secretary, Health Services Union (NSW/ACT/QLD)
- Ms Shaye Candish, General Secretary, NSW Nurses and Midwives' Association
- Ms Kelly Falconer, Registered Nurse and member, NSW Nurses and Midwives' Association.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:
- Dr Sue Velovski, General Surgeon, Ballina and Lismore and Committee member, Rural Doctors' Association of NSW
- Ms Suzanne Melchior, Senior Registered Nurse, Northern Rivers NSW.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:
- Dr Jaqueline Huber, Fellow, Royal Australian and New Zealand College of Psychiatrists
- Mr Christopher Stone, Policy and Government Relations Manager, Suicide Prevention Australia
- Miss Charlotte Gonzaga, Lived experience speaker, Batyr.

Mr Stone tendered the following document:
- Report, 'In their words: How to support young people in suicidal distress', Suicide Prevention Australia, August 2022.

The evidence concluded and the witnesses withdrew.

The media and public withdrew.

The hearing concluded at 4.45 pm.

4.5 Tendered documents

Resolved, on the motion of Mr Amato: That the committee accept and publish the following documents tendered during the public hearing:
- Report, 'Access block: A review of potential solutions', Sax Institute, September 2022, tendered by Dr Clare Skinner
- Report, 'The ANZSCO anomalies: An examination of the Australian and New Zealand standard classification of occupations (ANZCO) for paramedicine', Ray Bange OAM, August 2022, tendered by Associate Professor Ray Bange OAM
- Report, 'In their words: How to support young people in suicidal distress', Suicide Prevention Australia, August 2022, tendered by Mr Christopher Stone.

4.6 Confidential submissions

Resolved, on the motion of Ms Hurst: That the committee keep submission no. 30 confidential, as per the request of the author.

Adjournment

The committee adjourned at 4.50 pm until 9.15 am, Friday 7 October 2022, Room 814-815, Parliament House (public hearing).

Madeleine Foley
Committee Clerk

Minutes no. 69
Friday 7 October 2022
Portfolio Committee No. 2 – Health

Room 814-815, Parliament House, 9.17 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair* (from 11.15 am)
Mr Amato (via Webex)
Mr Buttigieg (substituting for Mr Secord)
Ms Faehrmann
Mr Farlow (substituting for Mr Fang)
Ms MacDonald

2. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

2.1 Public hearing

Witnesses, the public and media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Dr Michael Bonning, President, Australian Medical Association NSW.

The evidence concluded and witness withdrew.

The following witnesses were sworn and admitted:

- Dr Tony Sara, President, Australian Salaried Medical Officers' Federation
- Dr Liz Swinburn, Senior Emergency Physician, Royal North Shore Hospital
- Mr Jerry Yik, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia
- Dr Jonathan Penm, Chair, NSW Branch Committee, The Society of Hospital Pharmacists of Australia.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:

- Dr Kendall Bein, Emergency Department Staff Specialist
- Associate Professor James Mallows, Staff Specialist Emergency Physician and Director Emergency Medicine Research, Nepean Hospital.

Associate Professor Mallows tendered the following document:

- Document, 'Patient admissions'.

Dr Bein tendered the following document:

- Document, 'Patients admitted – 24 hours September 2022'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:

- Ms Sophie Dyson, Director, Taylor Fry Pty Ltd
- Associate Professor Graham Reece, Intensive Care Specialist and Director, Intensive Care, Blacktown Hospital.

Associate Professor Reece tendered the following document:

- Document, 'Gold chain – Inquiry into the impact of ambulance and ramping access block on the operation of hospital emergency departments in New South Wales', 7 October 2022.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and admitted:

- Ms Susan Pearce, Secretary, NSW Health
- Mr Matthew Daly, Deputy Secretary, Patient Experience and System Performance, NSW Health

- Dr Dominic Morgan, Commissioner and Chief Executive, NSW Ambulance.

The evidence concluded and the witnesses withdrew.

The media and public withdrew.

The hearing concluded at 3.12 pm.

2.2 Tendered documents

Resolved, on the motion of Ms Faehrmann: That the committee accept and publish the following documents tendered during the public hearing:

- Document, 'Patient admissions', tendered by Associate Professor Mallows
- Document, 'Patients admitted – 24 hours September 2022', tendered by Dr Kendall Bein
- Document, 'Gold chain – Inquiry into the impact of ambulance and ramping access block on the operation of hospital emergency departments in New South Wales', 7 October 2022, tendered by Associate Professor Reece.

3. Inquiry into Budget Estimates 2022-2023 – supplementary hearings

3.1 Supplementary hearings

Mr Buttigieg moved: That the committee:

- hold a further half-day hearing with the minister and department witnesses to consider matters relating to the portfolio of Health, on a date during the week of 24 October to 28 October 2022,
- hold no further hearings to consider matters relating to the portfolios of Women, Regional Health, Mental Health.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mr Donnelly, Ms Faehrmann, Ms Hurst.

Noes: Mr Amato, Mr Farlow, Mrs MacDonald.

Question resolved in the affirmative.

4. Adjournment

The committee adjourned at 3.18 pm until Monday 17 October 2022 (report deliberative – Primates and animal research).

Madeleine Foley
Committee Clerk

Minutes no. 70
Monday 17 October 2022
Portfolio Committee No. 2 - Health
Room 1043, Parliament House, Sydney at 10.03 am

1. Members present

Mr Donnelly, *Chair*
Ms Hurst, *Deputy Chair*
Mr Amato
Ms Boyd *(via videoconference)*
Mr Buttigieg *(substituting for Mr Secord from 2.07 pm)*
Mr Fang
Mr Graham *(substituting for Mr Secord from 12.00 pm to 2.07 pm)*
Mrs MacDonald *(from 12.38 pm)*

Mr Rath *(substituting for Mrs Mac Donald from 10.00 am to 11.00 am)*
Ms Sharpe *(substituting for Mr Secord from 10.00 am to 12.00 pm)*

2. Apologies
Mr Secord

3. Previous minutes
Resolved, on the motion of Mr Amato: That draft minutes nos. 68 and 69 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 27 September 2022 – Email – attachments from Professor Paul Middleton, Director, South Western Emergency Research Institute, providing a written summary of his verbal briefing to the committee, a published journal article comparing access block in Australian jurisdictions that was flagged during the meeting, and an embargoed report on the prevalence of access block in Australian emergency departments.
- 13 October 2022 – Letter from Mr Donnelly, Ms Faehrmann and Mr Secord, requesting a meeting of Portfolio Committee No. 2 to consider a proposed self-reference into a matter arising from Budget Estimates relating to the COVID-19 classification of the Minister for Health, the Hon Brad Hazzard MP.

5. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency department in New South Wales

Resolved, on the motion of Ms Hurst: That the committee publish the written summary of Professor Middleton's verbal briefing to the committee.

6. Inquiry into the use of primates and other animals in medical research in NSW

6.1 Partially confidential submissions (name suppressed)

Resolved, on the motion of Mr Fang: That the committee keep the following information confidential, as per the requests of the authors: names and/or identifying and sensitive information in submission nos. 55 and 321.

6.2 Confidential submissions

Resolved, on the motion of Mr Fang: That the committee keep submission nos. 210 and 292 confidential, as per the requests of the authors.

6.3 Correspondence from in camera witness

Resolved, on the motion of Mr Fang: That the committee keep the correspondence from Witness A dated 17 May 2022.

6.4 Answers to questions on notice
The committee noted that the following answers to questions on notice were published by the committee clerk under the resolutions appointing the committee:

- answers to questions on notice from Prof Robert Brink, Pillar Director in Translation Science, Garvan Institute of Medical Research, received 16 June 2022
- answers to questions on notice from RSPCA Australia and RSPCA NSW, received 22 June 2022
- answers to questions on notice Australian Academy of Health and Medical Sciences, NSW Branch, received 24 June 2022
- answers to questions on notice from Prof Peter Schofield AO, Board member, Association of Australian Medical Research Institutes, received 27 June 2022

- answers to questions on notice from Ms Rachel Smith Chief Executive Officer, Humane Research Australia, received 29 June 2022
- answers to questions on notice from Prof Kevin Dunn, Pro Vice-Chancellor Research, Western Sydney University, received 4 July 2022
- answers to questions on notice from Prof Philip O'Connell, Executive Director, Westmead Institute for Medical Research, received 4 July 2022
- answers to questions on notice from Ms Tara Ward, Managing Solicitor (Volunteer), Animal Defenders Office, received 4 July 2022
- answers to questions on notice from Dr Peter Johnson, received 4 July 2022
- answers to questions on notice from Prof Andrew Knight, received 15 July 2022
- additional information from Prof Andrew Knight, received 15 July 2022
- additional information from Dr Malcolm France, Board member and Convenor of the Openness Agreement, Australian & New Zealand Council for the Care of Animals in Research and Teaching, received 18 July 2022
- answers to questions on notice from Ms Nikki Steendam, President, Beagle Freedom Australia, received 20 July 2022
- answers to questions on notice from Dr Sarah Toole, Animal Welfare Officer and Veterinarian, University of Wollongong, received 21 July 2022
- answers to questions on notice from Dr Susan Maastricht, Director, Research Integrity and Ethics Administration, University of Sydney, received 22 July 2022
- answers to questions on notice from Prof Brian Kelly, Pro Vice-Chancellor (Research), University of Newcastle, received 22 July 2022
- answers to questions on notice from Ms Paula Wallace, Director, Liberty Foundation, received 22 July 2022
- answers to questions on notice from National Health and Medical Research Council, received 22 July 2022
- additional information from Prof Wayne Hawthorne, Chair, Animal Ethics Committee, Western Sydney Local Health District, received 27 July 2022
- answers to questions on notice from Department of Primary Industries, received 27 July 2022
- answers to questions on notice from Dr Rosemary Elliott, President and Dr Katherine van Ekert, Vice President, Sentient, received 1 August 2022
- answers to questions on notice from Mr Edwin Brackenreg, Chief Executive Officer, Codex Research, received 18 August 2022
- answers to questions on notice from Ms Sharyn Watson, Executive Director, Medical Advances Without Animals Trust, received 19 August 2022
- answers to questions on notice from Mr Troy Seidle, Vice President, Research & Toxicology, Humane Society International, received 21 August 2022
- answers to questions on notice from the Australian and New Zealand Laboratory Animals Association, received 6 September 2022.

6.5 Consideration of Chair's draft report

The Chair submitted his draft report, entitled *'Use of primates and other animals in medical research in New South Wales'*, which, having been previously circulated, was taken as being read.

Chapter 1

Resolved, on the motion of Ms Hurst: That paragraph 1.1 be amended by:

a) inserting 'by researchers' after 'Contributions to the inquiry'

b) omitting 'The committee was told of the benefits' and inserting instead ' The committee was also told by researchers of the benefits'

c) inserting 'from some participants' after 'the committee heard'.

Resolved, on the motion of Ms Hurst: That paragraph 1.8 be amended by:

a) omitting 'numerous contributors' and inserting instead 'Professor Anthony Cunningham AO, NSW And ACT Branch Chair, Australian Academy of Health and Medical Science'

b) omitting 'critical' and inserting instead "crucial"

c) inserting 'See also:' in footnote 9, before 'Evidence, Professor Philip O'Connell, Executive Director, the Westmead Institute for Medical Research, 16 May 2022, p 22.

Resolved, on the motion of Ms Hurst: That the following paragraph be inserted after the heading 'Research using primates':

"In NSW, primates are kept and bred for research at the Australian National Baboon Colony, which is 'maintained, managed and financially supported by Sydney Local Health District … The total Australian National Baboon Colony expenditure funded by the District for the 2021-22 financial year was $0.762 million." [FOOTNOTE: Responses to questions on notice, Budget Estimates 2021–2022 (Portfolio Committee No. 2 – Health (Health and Medical Research)), 7 September 2022, p 31.]

Resolved on the motion of Ms Hurst: That paragraph 1.13 be amended by

a) omitting "the extreme difficulty of meeting their physical and behavioural needs in a research environment' and inserting instead:

'Primates stand out among other taxa for their flexibility in how they respond to the world around them and their highly sophisticated and complex social and cognitive capacities. Therefore, meeting their needs in the research setting with the consequent spatial and social restrictions and limitations on choice and control is inevitably fraught. Therefore, it is difficult to ensure that these animals in a research setting can experience a good quality of life. It is on this basis that the RSPCA opposes the use of primates for research. [FOOTNOTE: Submission 222, RSPCA p 8]

b) inserting the following paragraph:

'Humane Research Australia agreed, noting that:

Primates are genetically the closest living creatures to humans. Their sentient ability is thought to be very similar to ours, as primates have complex social interactions. In contrast, a laboratory setting is far removed from the natural habitat. The average laboratory cage of the rhesus macaque is 7 million- fold smaller than their natural home range (40). Primate research is particularly contentious, presenting a clear ethical dilemma of using animals with high cognitive abilities, a long lifespan, and well-developed social structures as mere 'tools for research'. The animal welfare impacts associated with their advanced abilities are profound in a research setting, where they may associate previous negative experiences such as invasive procedures with future occurrences.' [FOOTNOTE: Submission 204, Humane Research Australia, p 12]

c) inserting a new paragraph from the sentence starting with 'Acknowledging this …'

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 1.15:

'Humane Research Australia agreed with this position, noting that:

It has been argued that primate research is essential to advance human health. Indeed, this is a common assumption due to their close genetic relationship to humans. Yet, we are separated by 25 million years of evolution. There are major anatomical, genetic, dietetic, environmental, toxic, and immune differences. Systematic reviews of primate research indicate that the perceived benefits to humans are overstated and that non-human 13 primate models have provided disappointing contributions toward human medical advancements' [FOOTNOTE: Submission 204, Humane Research Australia, p 8]

Resolved, on the motion of Ms Hurst: That paragraph 1.16 be amended by omitting 'numerous' before 'medical researchers'.

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 1.23:

'There was evidence from both research and animal advocates alike that more needs to be done to develop and move towards alternatives.'

Resolved, on the motion of Ms Hurst: That paragraphs 1.24 – 1.28 be moved after paragraph 1.18.

Resolved, on the motion of Ms Hurst: That paragraph 1.24 be amended by omitting 'Moves to replace the use of animals in medical research with alternatives align with the views expressed in a number of submissions received from private individuals'. and inserting instead:

'This inquiry received hundreds of submissions which included evidence from individual members of the public expressing their concerns around the ethics of the use of animals in medical research'.

Resolved, on the motion of Ms Hurst: That paragraph 1.25 be amended by inserting 'Individual' before 'submission authors'.

Resolved, on the motion of Ms Hurst: That paragraph 1.26 be omitted.

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 1.27:

'These concerns about the ethics of the use of animals in experimentation were echoed by animal protection organisations. The Animal Defenders Office observed that:

> Accountability and transparency in the animal medical research industry is minimal, to the point where it is questionable whether the industry can say it has a social licence to do what it does. Time and again we speak to members of our community who have no idea that animals are used for research in Australia. They think it does not happen here and that it was something that happened in the distant past but not anymore. They have wrongly assumed that we and science itself have progressed and moved beyond such antiquated methods. [FOOTNOTE: Evidence, Ms Tara Ward, Solicitor, Animal Defenders Office, 16 May 2022, p 38]

Sentient also raised concerns about the experience of animals used in medical research:

> This is hardly a life worth living. It is in the public interest to know this. The false dichotomy that it's either animal welfare or human health is an ongoing theme. This must be challenged because it silences debate around the real issue, which is that the suffering and needless death of sentient beings and the squandering of public funding to support this cannot be justified.' [FOOTNOTE: Evidence, Dr Rosemary Elliot, President, Sentient, the Veterinary Institute for Animal Ethics, 28 June 2022, p 3]

Resolved, on the motion of Ms Hurst: That paragraph 1.29 be amended by:

a) inserting 'some' before 'inquiry participants'

b) omitting 'outside the medical research community'

Resolved, on the motion of Ms Hurst: That paragraph 1.30 be amended by omitting: 'Submitters argued:

- 'animal research fails to predict human outcomes in the majority of cases'
- 'there are significant enough biological differences [between humans and animals] that wrong species often give the wrong result'
- 'the benefits [of using animals] are overstated, and that superior methods based on human biology are much needed to progress human health in the modern era'
- 'laboratory procedures and conditions exert influences on animals' physiology and behaviours that are difficult to control and can impact research outcomes'.'

and the following new paragraphs be inserted instead:

'For example, Mr Brackenreg of Codex Research expressed the view that 'animal research fails to predict human outcomes in the majority of cases'. Mr Troy Seidle, Vice-President, Research and Toxicology, Humane Society International expressed a similar view that:

> If we don't understand the fundamental human biology that we are trying to predict in whatever system we choose, you're going to get a very high failure rate. And why don't we understand the fundamental biology? Because we're spending so much time and resources looking at mice, dogs

> and even primates. There are significant enough biological differences that wrong species often give the wrong result.

Humane Research Australia also argued that 'the benefits [of using animals] are overstated, and that superior methods based on human-biology are much needed to progress human health in the modern era'. They explained that:

> Although even a single significant advancement is to be applauded, it must be considered in the context of a great number of failed cases, which indicate the unreliable and ineffective nature of animal models. It would be prudent to seek more consistently successful models that could produce a higher rate of significant contributions.

'In response to questions taken on notice, Sentient – The Veterinary Institute for Animal Ethics shared insights from a journal article about how the conditions in which animals are held in laboratories can affect research outcomes:

> Laboratory procedures and conditions exert influences on animals' physiology and behaviors that are difficult to control and can ultimately impact research outcomes and impede extrapolation to humans. Animals in laboratories are involuntarily placed in artificial environments, usually in windowless rooms, for the duration of their lives. Captivity and the common features of biomedical laboratories—such as artificial lighting, human-produced noises, and limited space and lack of environmental enrichment—can prevent species typical behaviors, causing distress and abnormal behaviors among animals.' [FOOTNOTE: Ashya Aktar, 'The Flaws and Human Harms of Animal Experimentation', Cambridge Quarterly of Healthcare Ethics (2015), issue 24, p 408, accessed 18 October 2022 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4594046/pdf/S0963180115000079a.pdf>.]

'Sentient added that animals 'are also exposed to social stressors, whether this is isolation or aggressive interactions between conspecifics'. [FOOTNOTE: Answers to questions on notice, Sentient - The Veterinary Institute for Animal Ethics, received 1 August 2022, p 8.]

Ms Hurst moved: That paragraph 1.59 be amended by:

a) omitting 'insightful' and 'and value'

b) omitting 'there is a general consensus that at this point in time, for various aspects of medical research, there is still an imperative to use animals.' and inserting instead 'there is a recognition that more needs to be done in the alternatives space'.

Question put.

The committee divided.

Ayes: Ms Hurst, Ms Boyd.

Noes: Mr Donnelly, Mr Amato, Mr Fang, Ms Sharpe.

Question resolved in the negative.

Resolved, on the motion of Ms Boyd: That paragraph 1.59 be amended by omitting 'there is a general consensus' and inserting instead 'the majority of the committee is of the view'.

Ms Hurst moved: That paragraph 1.60 be amended by omitting 'maintaining the reliance on animal methods for only so long as necessary before their progressive replacement with alternatives is possible.' and inserting instead 'to move towards alternatives as quickly as possible'.

Question put.

The committee divided.

Ayes: Ms Hurst, Ms Boyd.

Noes: Mr Donnelly, Mr Amato, Mr Fang, Ms Sharpe.

Question resolved in the negative.

Chapter 2

Resolved, on the motion of Ms Hurst: That paragraph 2.1 be amended by:

a) omitting 'creatures' and inserting instead 'animals'

b) omitting 'without their consent' after 'medical research'.

Resolved, on the motion of Ms Hurst: That paragraph 2.4 be amended by omitting 'On the other hand, the Kolling Institute provided a different view' and inserting instead 'The Kolling Institute provided the view'.

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 2.12:

'In addition, in relation to companion animals, Human Research Australia advised that healthy greyhounds are used for 'heart surgery experiments, terminal blood donation, and to test dental implants and deep brain stimulation devices" [FOOTNOTE: Submission 204, Humane Research Australia, p 13.]

Ms Sharpe left the meeting.

Mr Graham joined the meeting.

Resolved, on the motion of Ms Hurst: That paragraph 2.13 be amended by:

a) omitting 'animal welfare officer' and inserting instead 'animal care manager at research facilities'

b) omitting 'anecdotal' before 'evidence'

Resolved, on the motion of Ms Hurst: That the second paragraph of Case Study A be omitted: 'The test is grounded in theory that animals that spend more time floating (and less time swimming or attempting to escape) are feeling helpless and that this indicates depression or anxiety. Indeed, there is a correlation between the efficacy of some antidepressants and the outcomes of the test. However, some contradictory evidence has shown that floating is a learned and adaptive behaviour that saves energy and is beneficial for survival', and the following new paragraph be inserted instead:

'The test is grounded in theory that animals that spend more time floating (and less time swimming or attempting to escape) are feeling helpless and that this indicates depression or anxiety. There is a correlation between the efficacy of some antidepressants and the outcomes of the test. However, there have been questions raised as to whether this test is a good model for a complex, chronic condition like human depression, as contradictory evidence has shown that floating is a learned and adaptive behaviour that saves energy and is beneficial for survival.' [FOOTNOTE: Submission 222, RSPCA, p 9. See also Submission 204, Humane Research Australia, pp 10-11; Evidence, Dr Sarah Toole, Animal Welfare Officer & Veterinarian, University of Wollongong, 1 June 2022, pp 3-4; *In camera* evidence, Witness A, 16 May 2022, p 4.]

Resolved, on the motion of Ms Hurst: That the third paragraph of Case Study A be amended by inserting after 'the test is now only used with the aim of comparing it to alternative testing methods':

'Macquarie University has also publicly stated it will not use the forced swim test.' [Letter, Dr Karolyn White, Director, Research Ethics and Integrity, Deputy Vice-Chancellor (Research), Macquarie University to Dr Trunnell, Senior Scientist, Science Advancement and Outreach, PETA, 6 September 2022, published by PETA, <www.peta.org/wp-content/uploads/2022/09/macquarie-university-letter-to-peta.pdf> accessed 18 October 2022]

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 2.21:

'Wollongong University highlighted to the Committee some of their welfare concerns about the forced swim test:

> We have had some adverse events with that particular test. We had quite a few rats that were large, male rats that had been housed in conventional laboratory housing for a number of months. When they were in the forced swim test, we had some drownings occur… We had these incidents where the rats didn't die straightaway. Basically, it was aspiration of water that wasn't detected.

> The rats subsequently died, after the test. It was confirmed by post-mortem examination and histopathology on the lungs. Those issues were brought to the attention of the committee. The committee reviewed some videos of that test and subsequently decided that they would only allow that test if it was being used in parallel with an aim to look at alternatives to that test' [FOOTNOTE: Evidence, Dr Sarah Toole, Animal Welfare Officer and Veterinarian, University of Wollongong, 1 June 2022, pp 3-4]

Ms Hurst moved: That paragraph 2.37 be amended by:

a) omitting 'cannot ignore the overwhelming body of' and inserting instead 'received'

b) omitting 'the eminent representatives of' before 'the medical research community'

c) omitting 'We concur that the use of animals in medical research is justifiable on public health grounds, provided the animals are treated humanely' and inserting instead 'We recognise that all inquiry participants want to see an end of the use of animals in experimentation and a move toward alternatives'.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Graham.

Question resolved in the negative.

Resolved, on the motion of Mr Fang: That paragraph 2.37 be amended by:

a) omitting 'cannot ignore the overwhelming body of' and inserting instead 'received strong'

b) omitting 'We concur that the use of animals in medical research is justifiable on public health grounds, provided the animals are treated humanely' and inserting instead 'The majority of committee members acknowledge the use of animals in medical research is justifiable on public health grounds, provided the animals are treated humanely'.

Resolved, on the motion of Ms Hurst: That paragraph 2.40 be amended by omitting 'some of which can be mitigated by instead using whole of body exposure' and inserting instead 'on animals'.

Resolved, on the motion of Ms Hurst: That:

a) paragraph 2.42 be amended by:

   i. omitting 'should strive' and inserting instead 'strives'
   ii. omitting 'in medical research' after 'treatment of animals'
   iii. inserting 'rapidly' before 'phasing'

b) Recommendation 1 be amended by inserting 'rapidly' before 'phased out'.

Chapter 3

Resolved, on the motion of Ms Hurst: That paragraph 3.9 be amended by:

a) omitting 'receiving regular reports in relation to the projects approved'

b) omitting 'overlap considerably with the ARRP but they perform the following on an institutional rather than system wide level' and inserting instead 'include'.

Resolved, on the motion of Ms Hurst: That paragraph 3.14 be amended by:

a) omitting '• the ARRP oversees the AEC's decision-making, providing 'rigorous oversight with feedback from all the members'. The ARRP may reject the proposal or ask additional questions: "Have you considered this? What does this mean?"

b) omitting '• the ARRP responses go back to the AEC who 'considers that and decides whether or not to approve the protocol" and

c) inserting instead '• the AEC may reject the proposal or ask additional questions: "have you considered this What does this mean?"'

Mrs MacDonald joined the meeting.

Resolved, on the motion of Ms Hurst:

a) That paragraph 3.28 be amended by inserting the following new paragraph after 'far from robust':

'The Animal Defenders Office also expressed concern about the regulatory framework:

> The regulatory framework in NSW covering animal research is what is known as 'enforced self-regulation'. That is, while the legislation sets out requirements for carrying out the research, it is largely left to the industry itself to ensure the requirements are followed, and there is minimal oversight or intervention by external enforcement agencies (eg government departments). Researchers are required to obtain AEEC approval, but AEECs are established by the research institutions themselves and dominated by industry participants. There is little to no public reporting of research refused or modified by AEECs, or outcomes of AEEC inspections of institutions and laboratories, or AEEC or institutional responses to unexpected adverse events. Complaints are rare and prosecutions for non-compliance with regulatory requirements are even rarer. Self-regulation also carries a high risk of perceived and actual conflicts of interest as it depends on research institutions monitoring their compliance with regulatory requirements through their own AEECs.' [FOOTNOTE: Answers to supplementary questions, Ms Tara Ward, Solicitor, Animal Defenders Office, 4 July 2022, p 6]

b) That the following new paragraphs be inserted after paragraph 3.30:

'The RSPCA raised particular concern about the guidelines for the care and housing of animals used for experimentation, noting that many of the guidelines are over 20 years old and in need of updating:

> Animals in a research setting are generally maintained in controlled and contained environments. Most species used, including dogs, cats, rodents and primates, are social animals and their needs and natural behaviours are best supported when housed with others of the same species. In many circumstances, research requires animals to be isolated which can restrict the opportunities for them to engage in positive natural behaviours. Other aspects of the research environment restrict natural behaviour including the opportunity to forage, exercise and meet other highly motivated biological needs which can impact on their ability to live a good life. It has also been proven that maintaining good animal welfare leads to better quality scientific outcomes…
>
> Although the guidelines are now given mandatory effect by way of license conditions, to create regulatory certainty, the practice guidelines should be given force by being prescribed as a code or standard by the regulation. Many of these guidelines have not been reviewed in more than 20 years. They should be reviewed in the process of being prescribed.' [FOOTNOTE: Submission 222, RSPCA, p 7]

'A number of inquiry participants also called for a review of the Code, which has not been updated since 2013.' [FOOTNOTE: Submission 222, RSPCA, p 13; Submission 204, Humane Research Australia, p 16]

Resolved, on the motion of Ms Hurst: That paragraph 3.38 be amended by:

a) Inserting the following after 'have been knocked back':

'By contrast, Ms Tara Ward gave a different perspective based on her experience on an AEC:

> From my perspective as a Category C member of a university AEEC for over 5 years, the current system is not working when it comes to requiring researchers to consider alternatives. While researchers are required to address the issue on their research project applications, they frequently copy and paste standard wording stating that there are no alternatives currently available but that they are monitoring the literature. The AEEC can do nothing about this, short of asking further questions on each individual protocol and asking the researcher to provide details'.

[FOOTNOTE: Answers to supplementary questions, Animal Defenders Office, 4 July 2022, p 4.]

b) Omitting 'however' after 'Animal Defenders Office'

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 3.38:

'Medical Advances Without Animals raised concerns that animal ethics committees can be compromised by the current typical process, whereby funding is allocated to an animal research project prior to receiving ethics approval:

> AEC members also advise that timing can be important as once a proposal is presented to an AEC, it often has funding approval and that issues regarding animal ethics are among the last to be considered. In other countries there is ethical screening before funding decisions are made which avoids the problem of researchers, faculties and institutions having so much invested by the time the AEC is required to assess whether alternatives have truly been investigated. AEC members have said that they feel immense institutional pressure at times to approve projects despite their reservations.' [FOOTNOTE: Submission 351, Medical Advances Without Animals Trust, p 8.]

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 3.41:

'Professor Knight also argued that more needs to be done to encourage pre-registration of animal research, and publication of negative findings:

> To ensure that all such evidence is publicly available, greater efforts must also be made by researchers and editors to publish negative results. Studies that fail to show a treatment effect are often considered less interesting and are, consequently, less likely to be published. The subsequent exclusion of such results from systematic reviews leads to overestimations of treatment efficacy and partly explains the widespread failures in humans of treatments apparently efficacious in animals. Within the field of human studies, clinical trial registers allow researchers to learn about existing and prior clinical trials, including those with negative outcomes, before results are formally published. A similar international initiative to register animal studies and their results is warranted.' [FOOTNOTE: Submission 250, Professor Andrew Knight, p 4.]

'The RSPCA also expressed support for requiring the publication of negative results, to improve transparency in the industry:

> RSPCA recommends that all animal studies should be pre-registered on a central database, of which there are already many available, to ensure full reporting of study details and to encourage reporting of negative results to ensure this information becomes available at the end of the study. Most registries have an option to place an embargo on the pre-registered study for up to five years, after which time the details of the study become automatically publicly accessible. There is currently little incentive in Australia for researchers to publish negative findings. This leads to the risk of replication of studies by various researchers which could be avoided if there was a requirement to publish negative findings and make this data widely available. Without this requirement, there is likely to be publication bias.' [FOOTNOTE: Submission 222, RSPCA, p 3.]

'In relation to this issue, Professor Anthony Cunningham AO of the Australian Academy of Health and Medical Sciences alerted the committee to the government's online register for clinical trials while acknowledging the difficulties in publishing negative findings in other publications:

> One of the reasons why clinicaltrials.gov was set up was to ensure that all trials were registered and negative results were registered as well. Researchers like me often find ways to publish data that includes negative results as well, so you can publish the negative results side by side with the positive results. But I agree with you: It is very difficult to get journals to accept a pure negative study.' [FOOTNOTE: Evidence, Professor Anthony Cunningham AO, Australian Academy of Health and Medical Sciences, 16 May 2022, p 7. See also: Evidence, Professor Robert Brink, Pillar

> Director, Translational Science, Garvan Institute of Medical Research, 16 May 2022, p 35; Evidence, Dr Suzanne Fowler, Chief Science Officer, RSPCA Australia, 16 May 2022, p 41.]

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 3.42:

'Some inquiry participants also raised concerns about the fact that research projects could be approved despite objections from members of AECs. For example, in relation to the smoking tower experiments, Humane Research Australia stated that:

> it is very disappointing to see the University of Newcastle continue to use this method and for students to continue to be using that method there when, members of their own animal ethics committee— for many years, we have information that they have been objecting to that, but it is still continuing.' [FOOTNOTE: Evidence, Ms Rachel Smith, Chief Executive Officer, Humane Research Australia, 16 May 2022, p12.]

'Humane Research Australia elaborated that 'The research was seemingly allowed to continue despite the objections as approvals were made without consensus and relentless bullying, intimidation and refusals to act on the concerns raised led to AEC members with objections resigning" [Answers to supplementary questions, Ms Rachel Smith, Chief Executive Officer, Humane Research Australia, 29 June 2022, p 10.]

'Professor Jacqueline Phillips, Chair of the Animal Research Review Panel, cited relevant provisions of the *Australian code for the care and use of animals for scientific purposes* to provide clarity around what should happen if a consensus is not reached:

> I was going to clarify from the code. It is actually a provision in there—this is 2.3.11 in the code—that if consensus is still not achieved after, as you have described, discussion and attempt to resolve their differences and exploring with applicants ways of modifying the activity or the project, "the AEC should only proceed to a majority decision after members have been allowed a period of time to review their positions, followed by further discussion." [FOOTNOTE: Evidence, Professor Jacqueline Phillips, Chair, Animal Research Review Panel, 1 June 2022, p 57.]

Resolved, on the motion of Ms Hurst: That paragraph 3.43 be amended by omitting 'members of the public' and inserting instead 'lay committee members'.

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 3.44:

'Similarly, Medical Advances Without Animals in recognising that there was 'insufficient education and training for researchers and Animal Ethics Committee (AEC) members, and therefore insufficient knowledge of alternative animal replacement methods', suggested that there should be funding for 'education and training in alternatives for students, researchers and AEC members to increase awareness, knowledge and expertise in animal-free methods and technologies.' [FOOTNOTE: Submission 351, Medical Advances Without Animals Trust, pp 14-15.]

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 3.50:

'The Animal Defenders Office also expressed a number of concerns about the audit and inspection process:

> Carrying out pre-arranged inspections of research institutions every 3-4 years is manifestly inadequate to monitor the care of the many (often thousands) of animals kept at an institution. […] The ADO submits that unannounced inspections at least once a year would be the minimum that would be required to give a basic level of assurance that an institution is complying with animal welfare requirements.' [FOOTNOTE: Answers to supplementary questions, Ms Tara Ward, Solicitor, Animal Defenders Office, 4 July 2022, p 6.]

Ms Hurst moved: That paragraph 3.54 be amended by:

a) Omitting 'many AECs' and inserting instead 'while some AECs'

b) Omitting 'and make the welfare of animals their primary consideration. However' and inserting instead ‘there was variability among AECs'

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Donnelly, Mr Fang, Mr Graham, Mrs MacDonald.

Question resolved in the negative.

Mr Graham left the meeting.

Mr Buttigieg joined the meeting.

Resolved, on the motion of Ms Hurst: That Recommendation 2 be amended:

a) by inserting 'with the ability for online participation' after 'in-person seminars'

b) by inserting 'with the ability for online participation' after 'in-person induction training'

c) by inserting at the end 'and ensure all animal ethics committee members receive adequate training about the availability of alternatives'

Resolved, on the motion of Ms Hurst: That paragraph 3.56 be amended by omitting 'the highest standards of animal welfare' and inserting instead 'the requirements of the Code and regulatory framework'.

Resolved, on the motion of Mr Fang: That Recommendation 3 be amended by inserting 'as soon as practicable' after 'audits of animal research facilities'.

Chapter 4

Ms Hurst moved: That paragraph 4.1 be amended by omitting 'some' before 'evidence'.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Resolved, on the motion of Mrs MacDonald: That paragraph 4.1 be amended by omitting 'some' and inserting instead 'certain'.

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 4.4:

'Ms Craig also highlighted a number of other concerning animal welfare issues from her time working in animal research institutions:

> I have personally witnessed a significant number of animal welfare issues. This includes the removal of toes and tail tipping of adult animals, animals not being given appropriate anaesthesia and analgesia, mass culling of animals as researchers are not happy with preliminary data from them, animals used in horrific inappropriate smoke inhalation studies, animal fasted for excessive periods of time, severe and significant overproduction of animals.' [FOOTNOTE: Submission 251, Ms Lisa Craig, p 3.]

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 4.4:

'Ms Craig also raised concerns around wastage and excess breeding:

> Breeding of animals for research, including commercially available animals, occurs at institutions across Australia, resulting in significant overproduction and culling of excess animals. This includes mice, rats, and guinea pigs.' [FOOTNOTE: Submission 251, Ms Lisa Craig, p 3.]

'These concerns were echoed by the RSPCA:

> Where animal breeding is undertaken within institutions this must be well managed by highly trained and competent staff. The risk of overbreeding is significant with students often tasked with managing their own breeding colonies with minima l training and oversight in doing so. Well run facilities have their own breeding manager who is tasked with ensuring overbreeding does not occur and that best practice is undertaken to avoid wastage of animals. Wastage occurs when animals are bred in numbers in excess of need, and then not utilized but killed and disposed. To prevent wastage, institutions must be required to track and report breeding and usage statistics relevant to individual strains of animals and the reasons for any wastage. [FOOTNOTE: Submission 222, RSPCA, p 6.]

Resolved, on the motion of Ms Hurst: That paragraph 4.13 be amended by omitting 'employed there' and inserting instead 'employed at these two facilities'.

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 4.20:

'While additional training was clearly required for researchers and animal care staff, the inclusion of honours students in animal research raised its own set of concerns. Mr Peter Adamson, a former AEC member, said that in his experience 'much suffering is inflicted on animals by students so that they can submit research to gain Honours degrees and Ph.D's.' [FOOTNOTE: Submission 252, Mr Peter Adamson, p 1.] Humane Research Australia also highlighted some of their reservations about the use of honours students, noting that:

> It establishes a precent of using animals in research, does not equip students with skills needed to peruse advanced new approach methodologies, and is wasteful of animal lives in the projects where outcomes are known and the animals are simply used to demonstrate existing knowledge, which could be taught by other methods. There is also the potential of animal welfare impact if the students are not adequately trained or experienced. To reduce the number of animals used and bring about a change in future generations of researchers, HRA recommend that honours students are prohibited from using animals. This would also encourage supervisors to expand the research methodologies they use. [FOOTNOTE: Answers to supplementary questions, Ms Rachel Smith, Chief Executive Officer, Humane Research Australia, 29 June 2022, p 11.]

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 4.27:

'There were stakeholders who called for funding for rescue organisations who are performing the work of rehoming animals used in research institutions. For example, Liberty Project stated that:

> For the rehoming movement for ex-research animals to expand and become sustainable at scale, we believe industry and government must work together with rehoming organisations, most importantly, by providing funding and other support… it should not be left to the charitable sector to pay for rehoming of animals from government-owned or -run research facilities as is currently taking place.' [FOOTNOTE: Answers to supplementary questions, Ms Paula Wallace, Director, Liberty Project, 22 July 2022, p 6.]

'The call for funding was also supported by the Animal Defenders Office.' [FOOTNOTE: Submission 245, Animal Defenders Office, p 13.]

Resolved, on the motion of Ms Hurst: That paragraph 4.29 be amended by omitting 'and it was introduced into the Legislative Assembly for concurrence' and inserting instead:

'On 13 October 2022, the bill passed the Legislative Assembly with amendments. At the time of writing this Report, the amendments are awaiting consideration in the Legislative Council.'

Resolved, on the motion of Ms Hurst: That paragraph 4.31 be amended by omitting 'additional funding for veterinarians' and inserting instead 'additional funding and for veterinarians'.

Resolved, on the motion of Ms Hurst: That paragraph 4.43 be amended by inserting at the end:

'• Requiring the fate of all species used in research to be reported'

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 4.43:

'The Animal Defenders Office also expressed support for improved reporting of animal use statistics, particularly in relation to the reporting the 'fate of animals':

> Reporting on the fate of animals is mandatory only for domesticated dogs and cats used in research. Reporting is voluntary for all other animal groups. This is unacceptable from a transparency standpoint. […] Furthermore, there is no ethical justification for requiring reporting on cats and dogs but not other species. The ADO submits that reporting on the fate of all animals should be mandatory.' [Submission 245, Animal Defenders Office, p 13.]

Resolved, on the motion of Ms Hurst: That paragraph 4.56 be amended by omitting 'The committee acknowledges that the evidence of single inquiry participants is not always credible and persuasive. However' and inserting instead 'While only one witness provided direct evidence of witnessing cruelty inside a research facility'.

Ms Hurst moved: That paragraph 4.57 be amended by omitting 'The committee reiterates in the strongest terms that the use of animals in medical research is justifiable on public health grounds only if animals are treated humanely' and inserting instead 'The Committee strongly believes the inhumane treatment of animals in medical research would be unjustifiable'.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 4.57:

'The Committee notes the issues raised by some witnesses regarding the current regulatory framework, including but not limited to, overbreeding of animals, issues regarding pre-registration and publication of negative results from animal research experiments, the participation of honours students in animal research and the standards for housing and care of animals in research facilities. The Committee was also concerned to hear evidence about non-disclosure obligations imposed by the Animal Research Act, and the limited protections afforded to whistleblowers. The Committee recommends that NSW Government investigate opportunities for reform and undertake a review of the Animal Research Act 1985 with regards to the issues raised in this Inquiry.'

'Recommendation X
That the NSW Government investigate opportunities for reform and undertake a review of the Animal Research Act 1985 with consideration of the issues raised in this Inquiry, including but not limited to:

- The overbreeding of animals
- The need to encourage pre-registration and publication of negative results of experiments involving animals
- The issues concerning honours student undertaking animal research experiments
- The housing and care of animals used in animal experimentation
- The need for protections for whistleblowers who seek to raise concerns about the treatment of animals used for experimentation'

Ms Hurst moved:

- That a new paragraph be inserted after paragraph 4.57: 'The committee also notes that a number of witnesses raised concerns about the adequacy of the *Australian code for the care and use of animals for scientific purposes*, which has not been updated since 2013. We therefore recommend the NSW Government engage with the Australian Government on a ministerial level to advocate for a priority review of the Code.'

- That Recommendation 4 be moved after paragraph 4.57 and Recommendation 4 be amended by omitting:
  'to ensure that:
  • veterinarians with appropriate expertise are appointed to animal ethics committees
  • research institutions be required to employ a veterinarian.'
- That paragraph 4.58 be amended by omitting 'engage with the Australian Government at a ministerial level to advocate for priority review of the Code' and inserting instead 'take steps to amend the *Animal Research Act 1985*'.
- That a new recommendation be inserted after paragraph 4.58:
  Recommendation
  That the NSW Government amend the *Animal Research Act 1985* to ensure that:
  • veterinarians with appropriate expertise are appointed to animal ethics committees
  • research institutions be required to employ a veterinarian.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Mr Fang moved: That Recommendation 7 be amended by omitting 'commit to' and inserting instead 'consider'.

Question put.

The committee divided.

Ayes: Mr Amato, Mr Fang, Mrs MacDonald.

Noes: Ms Boyd, Mr Buttigieg, Mr Donnelly, Ms Hurst.

Question resolved in the negative.

Ms Hurst moved:

- That a new paragraph be inserted after paragraph 4.62: 'The committee notes that while the Animal Research Amendment (Right to Release) Bill 2022 appears likely to pass through NSW Parliament there is potential to expand rehoming efforts in the animal research space. The committee also notes the need to provide funding and support to organisations who are doing the work of rehoming animals used in medical research.'
- That Recommendation 7 be amended by inserting ', and investigate opportunities to provide funding and support to animal rescue organisations who rehome animals used in research' after 'Research Animal Rehoming Guidelines'.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Amato, Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Mr Buttigieg moved:

- That a new paragraph be inserted after paragraph 4.62: 'The committee notes that while the Animal Research Amendment (Right to Release) Bill 2022 appears likely to pass through NSW Parliament there is potential to expand rehoming efforts in the animal research space. The committee supports investigation of opportunities to provide support to organisations who are doing the work of rehoming animals used in medical research.'
- That Recommendation 7 be amended by inserting ', and investigate opportunities to provide support to animal rescue organisations who rehome animals used in medical research' after 'Research Animal Rehoming Guidelines'.

Question put.

The committee divided.

Ayes: Ms Boyd, Mr Buttigieg, Mr Donnelly, Ms Hurst

Noes: Mr Amato, Mr Fang, Mrs MacDonald

Question resolved in the affirmative.

Resolved, on the motion of Ms Hurst: That paragraph 4.63 be amended by omitting 'the unfortunate perception that medical research institutes have something to hide' and inserting instead 'public confusion about the use of animals in medical research.'

Resolved, on the motion of Ms Hurst: That a new committee comment and recommendation be inserted after the first sentence of paragraph 4.63:

'Both researchers using animals in medical research and animal advocacy organisations expressed concerns to the committee about the adequacy of reporting of statistics on animals used in medical research in New South Wales. The committee therefore calls on the NSW Government to consider the reporting of these statistics.

Recommendation

That the NSW Government consider the reporting of statistics surrounding animals used in medical research, including but not limited to:

• publishing an annual list of accredited animal research establishments, and the species of animals they experiment on

• reporting on the total numbers of animals bred (but not ultimately used) for animal research

• requiring the fate of all species used in research to be reported.

Resolved, on the motion of Mr Buttigieg: That the recommendation inserted after paragraph 4.63 be amended by inserting a final dot point: 'the separate reporting of animals used in observational studies.'

Resolved, on the motion of Ms Hurst: That paragraph 4.63 be amended by omitting 'These reporting requirements should exclude animals involved in observational studies' and inserting instead 'These reporting requirements should provide for the separate and discrete reporting of animals involved in observational studies'.

Resolved, on the motion of Ms Hurst: That Recommendation 9 be amended by inserting ', and explore opportunities to ensure all research institutions sign up to this Agreement.'

Chapter 5

Resolved, on the motion of Ms Hurst: That paragraph 5.13 be amended by inserting a new dot point at the start of the list: 'While the NSW Government uses taxpayer money to fund animal research, this funding is not separately recorded or reported and therefore the total amount is unclear.' [FOOTNOTE: Answers to questions on notice, Budget Estimates 2019-2020, Portfolio Committee No. 2 – Health (Health and Medical Research), Further hearing 12 March 2020, p 8]

Resolved, on the motion of Ms Hurst: That a new paragraph be inserted after paragraph 5.28:

'While a national approach in Australia is preferable, the ADO supports the creation of an interim state institution for the advancement of non-animal alternatives and technologies in New South Wales. At the very least, the NSW Government should allocate meaningful funding to programs and grants aimed at reducing the numbers of animals used in medical research. These measures would demonstrate New South Wales' commitment to the principle of replacement and would help define a timeline for phasing out animal use in medical research.' [Submission 245, Animal Defenders Office, p 5]

Resolved, on the motion of Ms Hurst: That paragraph 5.29 be amended by:

- omitting 'The opportunity' and inserting instead 'In the committee's view, there is an opportunity'
- omitting 'is not lost on the committee'.

Resolved, on the motion of Ms Hurst: That paragraph 5.30 be amended by inserting 'with a view towards ending the use of animals in medical research' after 'the state would be able to take the lead about how best to maximise the efficiency and ethics of medical research'.

Mr Fang moved: That Recommendation 10 be amended by omitting 'commit funding to enable' and inserting instead 'promote'.

Question put.

The committee divided.

Ayes: Mr Fang, Mrs MacDonald.

Noes: Ms Boyd, Mr Buttigieg, Mr Donnelly, Ms Hurst.

Question resolved in the negative.

Ms Hurst moved: That a new committee comment and recommendation be inserted after Recommendation 10:

The committee notes that while it is clear the NSW Government provides funding towards the use of animals in medical research, it was difficult for the committee to confirm precisely how much funding had been allocated. When public money is being spent, it is important that there be transparency and accountability. The committee recommends that the NSW Government report annually on both the amount of government funding being given to the use of animals in medical research, and the amount of funding given to the development of alternatives.

Recommendation

That the NSW Government report annually on the amount of government funding given to the use of animals in medical research and funding given to the development of alternatives.

Question put.

The committee divided.

Ayes: Ms Boyd, Mr Buttigieg, Mr Donnelly, Ms Hurst.

Noes: Mr Fang, Mrs MacDonald.

Question resolved in the affirmative.

Ms Hurst moved: That a new committee comment and recommendation be inserted after Recommendation 10:

The committee notes that all inquiry participants expressed the view that they would like to get to the point where animals are no longer being used for experimentation. This goal will not be achieved without government leadership and support, including the need for funding towards the development of more alternatives to the use of animals in experimentation. With that in mind, the committee recommends the NSW Government seek to develop a plan on how we can transition away from animal use and towards the use of the alternatives.

Recommendation

That the NSW Government seek to develop a plan on how we can transition away from animal use and towards the use of the alternatives.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Ms Hurst moved: That a new committee comment and recommendation be inserted after Recommendation 10:

Given the significant concerns raised in this inquiry about the routine cruelty inflicted on animals in research facilities, as well as the serious questions about the scientific validity of studies involving animals for human medical research, the Committee has serious reservations about the continued use of animals in experimentation. The Committee also believes that with a Government focus towards alternatives, the transition away from animals in experimentation can be achieved much faster. We therefore recommend the NSW Government commit to ending the use of animals in experimentation

Recommendation
That the NSW Government end the use of animals in medical research.

Question put.

The committee divided.

Ayes: Ms Boyd, Ms Hurst.

Noes: Mr Buttigieg, Mr Donnelly, Mr Fang, Mrs MacDonald.

Question resolved in the negative.

Resolved, on the motion of Mr Fang:

- The draft report as amended be the report of the committee and that the committee present the report to the House;
- The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
- Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- The secretariat is tabling the report on Friday 21 October 2022.

7. Adjournment
The committee adjourned at 4.16 pm, *sine die*.

Madeleine Foley
Committee Clerk

Draft minutes no. 73
Monday 5 December 2022
Portfolio Committee No. 2 - Health
Jean Garling Room, State Library, Sydney at 10.00 am

1. Members present
Mr Donnelly, Chair
Ms Hurst, Deputy Chair
Mr Amato (via WebEx)
Ms Faehrmann
Mr Fang (via WebEx)
Mrs Houssos (substituting for Mr Secord) (until 10.34 am) (via WebEx)
Ms MacDonald
Mr D'Adam (substituting for Mr Secord) (from 10.34 am) (via WebEx)

2. Apologies

3. Previous minutes
Resolved, on the motion of Ms Hurst: That draft minutes nos. 68 and 69 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 21 October 2022 – Email from Mr Christopher Cousins, Paramedic Specialist, NSW Ambulance, to the committee secretariat enclosing information on the Ministry of Health's Hospital Destination Matrix
- 24 October 2022 – Email from Ms Sophie Dyson, Director, Taylor Fry Pty Ltd, to the committee secretariat, providing additional information and context to her testimony of 7 October 2022.

5. Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

5.1 Answers to questions on notice and supplementary questions
The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to supplementary questions from Ms Shaye Candish, General Secretary, NSW Nurses and Midwives' Association, received 8 November 2022
- answers to questions on notice from Mr David Waters, Chief Executive, Council of Ambulance Authorities, received 3 November 2022
- answers to supplementary questions from Associate Professor Ray Bange OAM, received 4 November 2022
- answers to supplementary questions from Dr Clare Skinner, President, Australasian College of Emergency Medicine, received 7 November 2022
- answers to supplementary questions from Dr James Tadros, Emergency Medicine Staff Specialist, received 4 November 2022

- answers to supplementary questions from Dr Setthy Ung, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, received 7 November 2022
- answers to supplementary questions from Mr Gerard Hayes, Secretary, Health Services Union, received 7 November 2022
- answers to supplementary questions from A/Prof James Mallows of Nepean Hospital, received 7 November 2022
- answers to supplementary questions from Dr Jonathon Penm, Chair, NSW Branch Committee, Society of Hospital Pharmacists, received 15 November 2022
- answers to supplementary questions from Dr Kendall Bein, Emergency Department Staff Specialist, received 26 October 2022
- answers to supplementary questions from Dr Michael Bonning, President, AMA, received 8 November 2022
- answers to supplementary questions from Dr Tony Sara, President, Australian Salaried Medical Officers' Federation, received 9 November 2022
- answers to supplementary questions from NSW Health witnesses, received 8 November 2022.

5.2 Additional information from witnesses

The committee noted that it had received additional information from Ms Sophie Dyson of Taylor Fry Pty Ltd on ways to address access block and emergency department overcrowding (previously circulated), which was published by the committee clerk under the authorisation of the resolution appointing the committee

5.3 Consideration of Chair's draft report

The Chair submitted his draft report entitled *Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales*, which, having been previously circulated, was taken as being read.

Chapter 2

Resolved, on the motion of Ms Faehrmann: That the following new paragraph be inserted after paragraph 2.39:

'The Australian Paramedics Association in their submission raised the necessity for hospitals that experience bed block to "provide paramedics with a mobile work trailer for paramedics to use to write clinical notes, drink, and eat out of the elements. Paramedics cannot continue to huddle in sheets, work on trestle tables next to PPE bins, or feel on the brink of fainting due to heat stress."' [Footnote: Submission 19, Australian Paramedics Association, p 17].

Ms Faehrmann moved: That the following new committee comment be inserted after paragraph 2.61:

'The committee is concerned that paramedics are required to wait for extensive periods outside emergency departments without appropriate facilities. It is vital that paramedics are able to properly rest and shelter from adverse weather at hospitals experiencing bed block.'

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Mrs Houssos, Ms Hurst, Ms MacDonald

Noes: Mr Amato, Mr Fang

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new recommendation be inserted after paragraph 2.61:

'That NSW Health ensure that every hospital that experiences bed block provide dedicated paramedic work zones out of the elements'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Mrs Houssos, Ms Hurst, Ms MacDonald

Noes: Mr Amato, Mr Fang

Question resolved in the affirmative.

Chapter 3

Resolved, on the motion of Ms Hurst: That the following new paragraphs be inserted after paragraph 3.29:

A number of inquiry participants highlighted the benefits of the Extended Care Paramedic (ECP) program to deliver more at-home care to patients, away from hospitals, and expressed desire for the program to be expanded. For example, the Australian Paramedics Association gave evidence that:

> For every patient diverted from an emergency department, the Extended Care Paramedic (ECP) program saves the health system money, reduces pressure on the hospital system, and provides at home care to patients, helping them avoid costly and stressful visits to hospital. ECPs can provide antibiotics, fix catheters and gastronomy tubes, do sutures, address dislocations, and more. Despite the evident value they bring in avoiding transfers to hospital, the ECP program is routinely ignored by NSWA [Footnote: Submission 19, Australian Paramedics Association, p 14].

The Australasian College of Paramedicine particularly highlighted the ability of ECPs to provide at-home care for the ageing population, to assist rural and regional NSW.

> 'There is scope for Community/Extended Care Paramedic roles to be expanded in metropolitan, rural and remote communities, hospitals and health clinics, aged care and other critical primary health care settings. Expansion of these models of care could support hospital avoidance initiatives and potentially reduce costs to the health system associated with emergency department presentations. Additionally, it would improve chronic health conditions' management and reduce early entry into aged care.' [Submission 19, Australasian College of Paramedicine, p 9]

Ms Faehrmann moved: That paragraph 3.30 be amended by inserting the following after 'Both Mr Bruning and Associate Professor Ray Bange argued that New South Wales should follow Victoria's lead in establishing the position of Chief Paramedic Officer':

'Mr Bruning told the committee:

> In Victoria we have the one and only chief paramedic officer, who sits separate of the ambulance service and is able to provide advice as to how paramedics can be utilised in new, innovative and different ways. We saw through the initial start of COVID that it actually made a significant difference because paramedics were able to utilise much more widely than emergency response and to support the health system with taking care of COVID patients. We were able to leave nurses in hospital and those sorts of things. [Footnote: Evidence, Mr Bruning, 5 October 2022, p 22]'.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Faehrmann, Mrs Houssos, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That the following new paragraphs be inserted after paragraph 3.30:

4.97 'In its submission, the Australian Paramedics Association also raised concerns regarding the management of the ECP program prohibiting the training or transfer of ECPs in the regions, stating:

> NSWA has recently notified APA (NSW) that they intend to place location limits on specialist positions, disallowing specialists from moving between stations unless to an "identified" specialist position. To the knowledge of APA (NSW), there are no formally funded/identified ECP positions outside Sydney, Wollongong and Newcastle. This could mean that if any ECP wishes to move to a regional location, they may be forced to give up their specialist credentials.[307]'

Ms Hurst moved: That the following new paragraph be inserted after paragraph 3.80:

'Stakeholders, including the NSW Nurses and Midwives Association, argued that minimum staff-to-patient ratios must be part of the solution when it comes to addressing bed block and ambulance ramping:

> It is clear the failure to reform staffing models for the nursing and midwifery workforce is a major barrier to resolving the crisis, and without addressing this we will continue to see poor patient outcomes and financial waste within the system. Shift-by-shift minimum enforceable safe staffing levels through the implementation of ratios is proven to be effective in improving patient care, improving patient outcomes, preventing adverse outcomes and deaths, recruiting and retaining staff and saving costs. It is the only measure that can break the cycle of nurses leaving the system as recruitment processes struggle to keep up with the loss of staff.
>
> Recent experience in Queensland following the introduction of ratios into adult medical and surgical wards in 27 public hospitals in 2016, demonstrates that this investment in nursing care leads to better patient outcomes, shorter length of stay and lower re-admission rates.' [Submission 31, NSW Nurses and Midwives Association, p 3].

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

307 Submission 19, Australian Paramedics Association (NSW), p 14.

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new paragraph be inserted after paragraph 3.80:

'The NSW Nurses and Midwives Association also commented:

> Rather than responding to our ever-changing health system, the Nursing Hours Per Patient Day (NHPPD) staffing model continues to show that it is no longer fit for purpose. It is not transparent, and it is able to be manipulated'. [Footnote: Submission, 31, NSW Nurses and Midwives Association, p 26].

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Ms Hurst moved: That the following new paragraphs be inserted after paragraph 3.80:

'The committee also received evidence about how the current pay and conditions for health care staff in NSW may be contributing to a loss of staff who move to other states, for example:

> Due to our proximity to the border, recruitment has become almost impossible. Why wouldn't nurses be attracted to better pay and conditions on offer in Qld? Many non-government nursing services in Qld have better pay and conditions than the LHD.

The NSW Nurses and Midwives Association argued that 'the government must ensure that nursing and midwifery pay rates are greater than those available to Queensland and Victorian nurses and midwives in order to slow the interstate migration out of NSW.' [Footnote: Submission 31, NSW Nurses and Midwives Association, pp 5 and 14].

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Mrs MacDonald

Question resolved in the affirmative.

Ms Hurst moved: That the following new paragraph and recommendation be inserted after recommendation 1:

'The Committee also notes that, consistent with evidence given by peak bodies such as the NSW Nurses and Midwives Association, there is a pressing need to introduce minimum nurse and midwife staff-to-patient ratios in hospitals across NSW, particularly in emergency settings. Staff-to-patient ratios are a critical part of the solution in addressing ambulance ramping and bed block, as well as improving both patient safety and working conditions.

Recommendation X

That the NSW Government introduce minimum, safe staff-to-patient ratios for nursing and midwifery staff in hospitals.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr D'Adam, Mr Donnelly, Mr Fang, Mrs MacDonald

Question resolved in the negative.

Ms Faehrmann moved: That the following new recommendation be inserted before paragraph 3.128:

'That the NSW Government implement the NSW Nurse and Midwives 2022 award including their claim for minimum staff nurse to patient and midwife to patient ratios across different wards.'

Question put.

The committee divided.

Ayes: Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr D'Adam, Mr Donnelly, Mr Fang, Ms MacDonald

Question resolved in the negative.

Ms Hurst moved: That the following new paragraph be inserted after paragraph 3.82:

'Further, Dr Sara said: "The New South Wales health system is based on the unrostered, unpaid wages theft of the hospital system of young doctors. That's been well and truly established. So it needs cultural change. It needs a new award". [Footnote, Evidence, Dr Tony Sara, 7 October 2022, p 11].

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Ms Hurst moved: That the following new paragraph and recommendation be inserted after recommendation 1:

'The Committee is also concerned about the evidence received regarding the current pay and conditions of healthcare workers in NSW, and the risk that we may be losing experienced staff to other states due to better pay and conditions offered – which is likely to hamper efforts to increase staff in hospitals. The Committee therefore recommends that the NSW Government undertake a review of the pay and

conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.

Recommendation X

The NSW Government undertake a review of the pay and conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Mrs MacDonald

Question resolved in the affirmative.

Ms Faehrmann moved: That recommendation 3 be amended by omitting 'consider appointing a Chief Paramedic Officer' before 'based on the model in Victoria' and inserting instead 'appoints a Chief Paramedic Officer'.

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Ms Hurst moved: That the following new paragraph and recommendation be inserted after recommendation 3:

'The committee also acknowledges the evidence received about the important role played by Extended Care Paramedics (ECPs) and their potential to help reduce pressure on hospitals. The committee feels that the ECP program is currently underutilised, and recommends that the NSW Government invest in and expand the ECP program with a focus on assisting patients in aged care facilities, along with greater efforts to extend the program to rural and remote NSW.

Recommendation X

The NSW Government invest in, and expand the Extended Care Paramedic program with a focus on assisting patients in aged care facilities, along with greater efforts to extend the program to rural and remote NSW.'

Question put.

The committee divided.

Ayes: Ms Hurst, Mr D'Adam, Mr Donnelly, Ms Faehrmann

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new committee comment be inserted after Recommendation 3:

'The committee is concerned by NSW Ambulance's policies that are currently restricting the training and transfer of ECPs and ICPs in regional NSW.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Ms Faehrmann moved: That the following new recommendation be inserted after Recommendation 3:

'That the NSW Government remove all location limits to allow Extended Care Paramedics and Intensive Care Paramedics to retain their qualifications when transferring to a regional location.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Mrs MacDonald

Question resolved in the affirmative.

Chapter 4

Resolved, on the motion of Ms Hurst: That the following new paragraph be inserted after paragraph 4.95:

'The committee acknowledges that ambulance ramping, emergency department overcrowding and bed block is a complex, multifaceted problem, and one that is not going to be solved overnight. Many of the recommendations outlined in this report will take some time to implement and to take effect. Nonetheless, the current situation across hospitals in NSW is acute and is putting patient and staff safety at risk – so it is important to consider immediate, interim solutions as well. These immediate solutions will differ between hospitals and location, and require bespoke plans that consider the needs of each hospital rather than a one size fits all solution. The committee therefore recommends that the NSW Government work with hospitals to develop interim solutions on a hospital-by-hospital basis to assist with ambulance ramping, emergency department overcrowding and bed block, to provide short-term relief while long term solutions are being implemented.

Recommendation X

The NSW Government work with hospitals to develop interim solutions on a hospital-by-hospital basis to assist with ambulance ramping, emergency department overcrowding and bed block, to provide short-term relief while long term solutions are being implemented.'

Chapter 3

Mr D'Adam moved: That the following amendment as moved by Ms Hurst be reconsidered:

'That the following new paragraph and recommendation be inserted after recommendation 1:

'The Committee is also concerned about the evidence received regarding the current pay and conditions of healthcare workers in NSW, and the risk that we may be losing experienced staff to other states due to better pay and conditions offered – which is likely to hamper efforts to increase staff in hospitals. The Committee therefore recommends that the NSW Government undertake a review of the pay and conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.

Recommendation X

The NSW Government undertake a review of the pay and conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.'

Question put.

The committee divided.

Ayes: Mr Amato, Mr D'Adam, Mr Donnelly, Mr Fang, Mrs MacDonald

Noes: Ms Faehrmann, Ms Hurst

Question resolved in the affirmative.

Ms Hurst moved: That the following new paragraph and recommendation be inserted after recommendation 1:

'The Committee is also concerned about the evidence received regarding the current pay and conditions of healthcare workers in NSW, and the risk that we may be losing experienced staff to other states due to better pay and conditions offered – which is likely to hamper efforts to increase staff in hospitals. The Committee therefore recommends that the NSW Government undertake a review of the pay and conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.

Recommendation X

The NSW Government undertake a review of the pay and conditions of junior doctors, paramedics, nurses, midwives and other healthcare staff, to ensure that the pay and conditions are appropriate and competitive with other states, and that NSW is able to recruit and retain healthcare staff.'

Question put.

The committee divided.

Ayes: Ms Hurst, Mr Faehrmann

Noes: Mr Amato, Mr D'Adam, Mr Donnelly, Mr Fang, Mrs MacDonald

Question resolved in the negative.

Mr D'Adam moved: That the following new paragraph and recommendation be inserted after recommendation 1:

> 'The committee is also concerned about the evidence received regarding the current pay and conditions of healthcare workers in New South Wales, and the risk that we may be losing experienced staff to other states due to better pay and conditions offered – which is likely to hamper efforts to increase staff in hospitals. The committee therefore recommends that the NSW Government abolish the wages cap for state sector employees including junior doctors, paramedics, nurses, midwives and other healthcare staff, and move to a system of productivity based bargaining to deliver fair wages, productivity growth, and better public services to the people of New South Wales.
>
> **Recommendation X**
>
> That the NSW Government abolish the wages cap and move to a system of productivity based bargaining to deliver fair wages, productivity growth, and better public services to the people of New South Wales.'

Question put.

The committee divided.

Ayes: Mr D'Adam, Mr Donnelly, Ms Faehrmann, Ms Hurst

Noes: Mr Amato, Mr Fang, Ms MacDonald

Question resolved in the affirmative.

Resolved, on the motion of Ms Faehrmann: That:

- The draft report as amended be the report of the committee and that the committee present the report to the House;
- The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions and correspondence relating to the inquiry be tabled in the House with the report;
- Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- The secretariat is tabling the report at 10 am on Thursday 8 December 2022.

6. Adjournment

The committee adjourned at 11.46 am.

Madeleine Foley
Committee Clerk

Appendix 4 Dissenting statement

The Hon Emma Hurst, MLC, Animal Justice Party

The Animal Justice Party moved a recommendation to this Inquiry report calling for mandatory minimum staff-to-patient ratios for nurses and midwives, which was rejected by both the Liberal-National Government and Labor Opposition.

This is incredibly disappointing.

Once again, it exposes the fact that neither major party is willing to take the current crisis in our hospital system seriously.

The problems of ambulance ramping and bed-block are multifaceted and complex. Ratios are a critical component of the solution. Without consistent safe staffing levels, our healthcare system will continue to be compromised and nurses and midwives will continue to be overworked and put in difficult, and sometimes even dangerous situations. The Animal Justice Party supports the industry's calls for mandatory minimum staff-to-patient ratios.