# PORTFOLIO COMMITTEE NO. 2 – HEALTH

## INQUIRY INTO THE IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

### HEARING 5 OCTOBER 2022

**Supplementary questions directed to Associate Professor Ray Bange OAM:**

*Answers are to be returned to the Committee secretariat by COB Monday 7 November 2022*

1. Would you say that the increased demand on our Emergency Departments has been predictable?

The issue of increasing demand for Emergency Departments (EDs) is not new and health industry experts and their representatives have been raising the matter and providing evidence of demand and proposed solutions for many years.

For NSW, the data from the Bureau of Health Information should also provide a source of definitive evidence of the demand over time for EDs.

2. Should more planning have been done to address this before it reached crisis levels that we see today?

Without knowing all activities that may have been undertaken by each stakeholder, the question may be one of planning or may be one of other pillars that make up governance.

The multi-variant and dynamic nature of the issue may well require levels of test-and-adjust, with no single measure fully resolving the situation at any time or even on an ongoing basis.

Some answers to this question are likely found by reviewing the response to question 1 above and the evidence provided over past years.

3. What impacts is this having on the paramedics' own health and wellbeing?

The impact on individual paramedics will vary, but substantial evidence is available in surveys and statements from paramedics and their representative bodies over many years that indicate an overwhelming negative impact. Examples were outlined on page 7 of my submission.

These views have been confirmed by numerous personal approaches outlining the impact on individual health and wellbeing, burn out, proposed resignations and early retirement. The personal toll in some cases has been horrendous with PTSI/PTSD outcomes.

These impacts should be viewed in the context of a workforce that is more educated and at a time when employees are more mobile/transient and have greater expectations of an ability to hold systems, organisations and leaders to account.

In the longer term the ambulance service needs to be seen as an employer of choice and measures put in place to ensure that goal.

4. I note in your submission that you talk about extended scopes of practice for paramedics. Can you please further explain what the extended scope could include?

With sound education and training (which is in place and growing) the scope of paramedic practice has moved from basic first aid to critical care in the last 40 years. It has moved from seeing the practitioner from being principally a transport only 'trade' to an independently registered health profession with evolving self-regulation and accountability.

This professionalisation sets the stage for a profession that can continue to adapt to deliver care in ways not previously envisaged. Paramedics today perform interventions that were once openly challenged, and which often fills the gap in healthcare by providing solutions to complex public health problems in the community.

Paramedic scope is likely to include a growth in the 'extended care', public health and occupational space such as:

- School paramedic (historically school nurses)
- Worksite paramedics (already in place and growing)
- Paramedic Practitioners in primary health care (medical centres etc)
- Paramedic Consultants holding responsibility for the determination and oversight of paramedic practice
- Participation in and operational leadership of multidisciplinary health teams
- Telehealth/virtual care (already in place)
- Palliative care.

Looking at more granular activities (many jurisdictions are already undertaking):

- Suturing & wound care
- Administration of antibiotics
- Point of care testing (ultrasound, blood gas analysis)
- Acute mental health assessment and referral
- Care plan review and preparation
- Site medical care risk assessment and planning
- Blood management and administration
- Advanced emergent airway management
- Remote and regional emergent and urgent care triage

I referred in my submission to the Additional Roles Reimbursement Scheme (ARRS) that was introduced in England in 2019 as a key part of the commitment to improve access to general practice by engaging additional staff. https://bit.ly/3Ewjxkk

While Primary Care Networks (PCNs) have swiftly recruited to these roles, some concern has been expressed that they are not being implemented and integrated into primary care teams effectively.

The King's fund has researched the issues related to implementation, looking at the experiences of people working in these roles and those managing them. https://bit.ly/37yR3uh

The study found a lack of shared understanding about the potential contribution of the roles, combined with an overall ambiguity about what multidisciplinary working would mean for GPs.

The result is that successful implementation requires extensive cultural, organisational and leadership development skills that are not easily accessible to PCNs (or PHNs in Australia).

Transitioning practices to multidisciplinary teams has been recognised as a challenge, and in January 2021, NHS Health Education England published a roadmap to practice for England First Contact Paramedic Practitioners into primary care. https://bit.ly/3K18UXY

The diversity of paramedicine also has been supported in the UK by the College of Paramedics where the Paramedic Career Framework showcases the evolving variety of roles being undertaken by paramedics across primary, urgent, emergency, and critical care. https://bit.ly/3Oo1bH6

Increasing research into the role of Paramedic Practitioners outside the ambulance sector and working in integrated and multi-disciplinary teams shows much remains to be done.

A recent scoping review is that conducted by Allana, Tavares, Pinto and Kuluski writing in the International Journal of Integrated Care: *Designing and Governing Responsive Local Care Systems – Insights from a Scoping Review of Paramedics in Integrated Models of Care.* https://bit.ly/3MgdAL7

The review suggests integrated care may be supported by a generalist health workforce, through cross-cutting organisations that work across silos, and legislation that balances standardisation with flexibility.

This study found that paramedics are often bridging gaps between acute and chronic care for a broad range of populations and serving as additional human resource for public health initiatives.

This suggests that connectivity and collaboration in local care systems can be enhanced by organisations with a generalist workforce that extends the reach of existing services through a single point-of-care.

Among the issues was the determination of the appropriate skill mix of professionals, addressing differences in professional norms, and regulation and payment mechanisms to support such services.

I reiterate the importance of understanding the integration issues involved in implementing additional allied health/paramedic professionals in primary care.

These issues have been raised with the Rural Health Workforce Agency network which (in the author's view) needs to incorporate allied health/paramedicine more effectively in their governance structure, Workforce Needs Analysis, and administration of Scholarship and other programs that they currently perform on behalf of government.

In past submissions to government Inquiries, I have raised the need for action to drive a deeper understanding of allied health skillsets so that primary care patients can reap the benefits of additional expertise through better mobilisation of the paramedicine workforce e.g. Tasmania. https://bit.ly/3xBxs7l

I also refer the Inquiry to the Final Report of the Tasmanian Rural Health Inquiry released on the 25 October and which contains considerable content dealing with the implementation of integrated health services. https://bit.ly/3N0bVeq

5. How would you describe the current measures implemented by the Government and NSW Health in dealing with ramping?

I can address this question only from my own (single and limited) perspective:

- Data from sources such as BHI refer to frequent challenges across the ambulance service and hospitals to meet KPIs, either frequently or on an ongoing basis.
- The ongoing and consistent volume of evidence advanced over many years by paramedics and their representative bodies (both industrial and professional) refer to negative experiences by patients and healthcare workers relating to response times and/or offload times.
- The problems articulated on an ongoing basis by culturally different professional organisations, such as; ACP, HSU, ACEM etc (with quite different membership, language and tone) describe strikingly similar challenges (in context).
- Peer reviewed literature and a multitude of reviews describe ongoing and systemic challenges with recommended solutions that so far do not appear to have been fully implemented or reflected in the experiences being described by paramedics and their representative bodies.
- It must be recognised that many parts of the system likely to have an impact on ramping are managed by or influenced by the federal government and private service providers.

6. In addition to your testimony, what strategies are the top priority that you think need implementing in order to address ramping?

If we want to free up paramedics in ambulances to respond to more patients, then we need to increase bed availability in the ED or other receiving portal to reduce offload time. That means having a throughput capacity from initiation of care to discharge sufficient to meet the instantaneous demand or cater for (smooth out) peak loads within an acceptable time frame.

Another option is to also reduce the number of patients presenting to hospital EDs by early preventive and primary care or diversion to more appropriate care facilities. Examples of this option were addressed in pages 20-23 of my submission.

The evidence provided by Dr Kendall Bein is suggested as providing good guidance. Some strategies may be:

- Education campaigns regarding alternative destinations and self-presentation methods (evidence indicates this does not have a large impact).

- Publish individual hospital bed availability and transfer-of-care dashboards to the public in real-time (again this assumes a rational user and semi-predictable demand).
- Alternatives to Emergency Departments for non-emergency (defining 'emergency' as life, limb or sight-threatening or acute pain or mental health and the like):
    - Primary health clinics (located appropriately or next to ED)
    - Better GP availability and sufficient time (reduce the sausage factory that sees patients spending 15 minutes or less with their GP).
    - More Extended Care Paramedics and more low acuity scope for general paramedics
    - Multi-disciplinary teams of nurses, paramedics, occupational therapist etc. that can focus on complex low-acuity care for patients who have ongoing needs that do not yet meet the threshold for residential care.
- More systems (that are integrated) to help navigate patients to where they need to go:
    - Virtual Care Centers
    - Telehealth (general)
    - Virtual ED telehealth services
- Increasing the size of ED facilities and staffing to provide more capacity (even if more alternatives to ED become available). Accept that Australians expect to have the right to turn up to the quickest care available (even if it's not the right one).
- More aged care facilities that are more accessible and financially achievable for residents/families.
- Consultant specialists (VMO) doing public hospital ward rounds (and hence discharges) when they are needed, not when it suits the provider.
- Better liaison with community services to enable exit/discharge from hospitals on weekends and other times.

When examining the available options, a series of questions might be considered in assessing them across the various stages of care.

1. Patient self-presents at ED – why? Are there sufficient GPs to look after the population? Enough bulk billing or sustainably remunerated GPs? Are GP services reasonably spread geographically? Are there other alternatives to ED presentation/diversion such as walk-in clinics? How comprehensive are the other primary health care (PHC) initiatives?

2. Out of hospital Mental Health issues/crises: Are there enough community mental health resources, including after-hours access? Are there acute MH diversionary programs like PACER?

3. Patient calls ambulance to treat/transport them to ED: Is the initial triage appropriate? Is there a functional Secondary Triage with robust diversionary options to PHC? Are ambulances transporting patients to appropriate facilities with services to negate need for later transfers?

4. ED Triage: Is it efficient? Rapid? Appropriate? Do they have access to alternative treatment options such as CALMs in the ACT (Canberra After Hours Medical Service)? Are there Urgent Care Centres available as an alternative?

5. ED efficiency: Are the EDs well-staffed with good nurse patient ratios? Do they have good throughput processes? Good access to allied health support 24 hours: x-ray/sonography/ imaging/physio/social work? Good access to specialists/registrars for reviews? Access to mental health specialists on site for treatment and review? Is there access to appropriately staffed after hours operating theatres for surgery? Are there appropriate bed numbers in the ED and hospital with a surge capacity?

6. Hospital efficiency: This is like the ED handling and throughput issues but applied across the wider hospital. Are diversionary options adequate, e.g., specialist rehab hospitals, mental health units, paediatric referral options, community health follow up options? Are there good discharge processes with clear referral pathways for follow ups to prevent re-presentations?

7. After treatment/discharge: Are there appropriate follow ups in the community, e.g., community nursing, GP Walk In centres where patients can be supported/reviewed to prevent ED re-presentations, either in person or by ambulance?

The choke points across the system undoubtedly vary geographically and resourcing of the wider system impacts on all of this, but smart coordinated throughput processes and flexible policies that recognise preventive and primary care and the social determinants of health will go a long way towards effecting lasting change.

When considering global solutions, given the hybrid public/private health and care system, there is a need for a powerful oversight body that can address the choke points in the system and which is independent of the usual political cycle.

As a statutory body this Commission/body could be given a clear mandate on what is to be achieved and suitable terms of reference. There are strong grounds for such a body to be at the Federal level to achieve national coordination and oversight, along with equity of outcomes.

Ray Bange OAM
4 November 2022