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Portfolio Committee No. 2 – Health
Legislative Council
Parliament House
6 Macquarie St
Sydney NSW 2000

Sent via email: PortfolioCommittee2@parliament.nsw.gov.au

Dear Committee Members

This letter contains responses to supplementary questions from the *Inquiry into the Impact of Ambulance Ramping and Access Block in New South Wales*, arising from the public hearing on 5 October 2022, attended by Dr Clare Skinner, President of the Australasian College for Emergency Medicine (ACEM; the College) and Mr James Gray, ACEM's Policy and Advocacy Manager.

1. Correction to transcript

In the uncorrected transcript provided to us, the first line attributed to Dr Skinner is that 'I work as a senior staff specialist in emergency medicine at Hornsby Ku-ring-gai Hospital in northern Sydney.' This information was provided as part of the affirmation, rather than at the start of the opening statement as it has been placed in the transcript.

We request that this information be listed in the top line before the statement 'affirmed and examined'. By listing it at the start of the statement it may lead people to believe that Dr Skinner was representing the hospital, rather than ACEM.

Alternatively, the following could be used – 'I am President of the Australasian College for Emergency Medicine and attend today to represent specialist emergency physicians and trainees working in emergency departments across New South Wales. I work clinically as a senior staff specialist in emergency medicine at Hornsby Ku-ring-gai Hospital in northern Sydney.'

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

2.1 Utilise Existing Programs and Supports

First and foremost, 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 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.

2.2 Improving Capacity and Flow

Fundamentally, access block and associated ambulance ramping is associated with a lack of capacity within the hospital system to allow for timely transfer to in-patient wards.

There are two ways to consider this lack of in-patient capacity, both of which require attention. The first is to look at existing capacity from the perspective of the number of staffed beds in the system. One option is to increase the number of beds available, and to ensure hospital beds are matched to population need and type of condition. For instance, the chronic shortage of acute mental health beds results in patients with mental health conditions experiencing the worst access block and delays to definitive care. There are also beds sequestered in specialist units for management of patients with tightly-defined sub-specialist conditions which are then not available for management of the larger group of patients who have more general, multi-system needs.

The second is to look at capacity from a patient flow perspective. In this scenario, we consider how patients can undertake a timely transition from Emergency Departments (ED) into the hospital, can receive efficient acute hospital care, and then move into appropriate step-down services in community settings. This necessitates sufficiently resourced and coordinated primary care services. Therefore, existing resources and beds are used by the patients that need them the most, and clearly defined and signposted systems help patients move through the hospital, then navigate and receive care in the community when that is clinically appropriate.

A practical step to improve patient flow would be to focus on reorganising the working day of in-patient units to support medical ward rounds and other routine processes to occur in a timely and predictable manner. This would also have the advantage of supporting junior doctors and optimising senior decision making. The details of this would require careful collaboration with medical colleagues in other parts of the hospital but would also reflect the need to treat the solutions to access block as a whole of hospital issue.

Finally, improvements in patient flow may also be gained by addressing instances of low value care, for example routine daily blood tests which may not alter clinical care decisions but consume significant resources. Medicine is a highly complex professional field, and it takes time for changes in practice to emanate through the system. By focusing on evidenced base practice, there is the opportunity to reduce the time, financial and environmental costs of unnecessary or sometimes harmful diagnostic tests and treatments.

2.3 State/Federal Collaboration

It will take cross-government commitment to address both capacity limitations to have a substantive impact on access block and ramping. Investment in services beyond the traditional in-patient hospital ward model has the potential to be cheaper in the long run, while maintaining or improving the quality and experience of patient care.

This type of reform requires better integration between primary and hospital care. Given the structure of our health system, success will require the NSW government and Federal government to work collaboratively to ensure that funding and governance issues do not act as a barrier to the transition of care across the hospital/community interface. Consideration should be given for progressing this work through the National Cabinet or the Health Minister's Meeting.

Closely connected to this is the national challenge of recruiting and retaining staff with the right skills in the right locations. As noted in the public hearing, the loss of experienced nursing staff is particularly problematic, but many health professions are facing this problem. The lack of appropriately trained medical staff is also causing a rapid escalation in the cost of using locums. Unless this is addressed with urgency, the bidding war that is currently occurring between jurisdictions could become a vicious cycle, whereby medical staff are incentivised to leave ongoing roles to become locums due to the high pay on offer, creating more vacancies, driving more demand for locums. While locums can provide high quality care, they do so as part of a team that is aware of local systems and processes, and without that local knowledge, clinical risk increases. States and territories have primary responsibility for the healthcare workforce, but there is space for a degree of federal coordination to avoid these types of problems. A locum pay cap, with appropriate indexation for regional, rural and remote areas, as well as more streamlined recruitment and credentialling processes, should be considered by National Cabinet.

An area that was not explored in detail in our testimony, was the impact of insufficient resourcing to primary care, particularly through General Practice (GP) and Residential Aged Care Facilities (RACFs). Smoothing the interface between these services and hospitals is a practical step that can happen quickly. Examples of the types of activities that have been previously successful but are typically unfunded include the use of GP liaison officers who can facilitate communication and referrals between the hospital and primary care, and RACF outreach from the hospital, inclusive of ED input, with the goal of providing in situ clinical care and capacity building. Digital solutions could also assist, such as high-quality medical history and medication records, which could be constructed using programs or apps with good templates, plus system interoperability and transferability, with funded support to GPs to compile these records. Some of this system navigation and integration role was supposed to be included in the role of Primary Health Networks (PHNs), however we see limited evidence of impact at this stage, likely explained at least in part by the very limited resources available to PHNs. The promise of My Health Record to share patient data across the system is also yet to be fully realised.

2.4 Sax Institute Recommendations

A recent review conducted by the Sax Institute highlighted four areas of focus. These reflect approaches that have been described in the literature and do not preclude other approaches being trialled.

1. Interventions to achieve reductions hospital bed occupancy, by increasing hospital inpatient bed capacity and freeing of inpatient beds. Many measures designed to free inpatient beds have been implemented across Australian and Aotearoa New Zealand health services.
2. The establishment of short-stay units, acute medical units and acute surgical units, where patients admitted via an ED can be accommodated, typically for up to 24 hours but sometimes longer, while receiving appropriate multidisciplinary specialist management prior to discharge or transfer to a subspecialty inpatient service.
3. Interventions to expedite patients' transition through the ED/inpatient service interface. Decisions as to the subspecialty inpatient service that is to accept an admitted patient are often complex and can only be resolved by negotiations between ED staff and inpatient teams or between different inpatient teams. This results in delays and can create significant tension. The interventions include recognition of the different imperatives of ED staff and inpatient teams, processes to promote mutual understanding and respect, and leadership that promotes communication and a favourable working environment which is not dominated by power differentials among healthcare professionals.
4. The maintenance of health system-wide time targets for admitted and non-admitted patients' transit through EDs, applied with sufficient flexibility to assure patient safety. The achievement of these targets depends on system and process changes which individually may not affect access block but are effective as combinations of initiatives within a performance-driven ethos.

A copy of the full report was provided to the committee at the public hearing and is also available on the ACEM website.

3. I note that your college has previously said in a media release on 17 May 2021 "This has been predictable and should have been planned for." Would you please explain why it was predictable and what planning should have been undertaken?

The referenced statement reflects that ACEM has been raising concerns about access block for over two decades. As the medical speciality with the greatest interest and knowledge of both the causative factors and impacts of access block and ambulance ramping, ACEM will always be available to consult with governments about the best ways to address these issues.

There is a large degree of predictability in the numbers of patients attending emergency departments. The nature of the work is that we don't know specifically which patients will require emergency care, but we can predict how many and at what particular times we will most likely be busy, and the range of problems for which patients are likely to require treatment and support.

Building on this, Australian governments have access to high quality data about trends in both emergency presentations and population growth. Therefore, demand for emergency care can be modelled with a strong degree of reliability. There are similar data available for the needs for in-patient beds. Planning for services should take into account both these data sources, yet we have seen a drop in capacity within the hospital system in terms of staffed beds, without commensurate investment in community-based services which could theoretically take some of the role of supporting patients.

Emergency presentations have been growing faster than population for many years, but health system planning has failed to provide sufficient capacity to address these presentations. It is important to note in this context (as in the original 17 May 2021 media release), that low acuity patients (sometimes incorrectly referred to as GP-type patients) are not the problem. The problem is the lack of capacity for patients that require admission to an in-patient ward.

As discussed in the response to the previous supplementary questions, hospital capacity must be addressed from the perspective of increasing the number of ED-accessible staffed beds and improving patient flow within the hospital, as well as investing in community and primary care to support the transition of patients out of hospital and into appropriate care more readily. This includes understanding the disaster preparedness needs of the health system. When hospitals are expected to regularly work over their funded capacity, the system cannot be resilient in the face of disasters.

The media statement referred to in this question was focused on the importance of improved coordination between state and territory governments, and the federal government. That point deserves re-emphasising here. A significant concern of the College is that due to the complexity of this problem, that responsibility shifting will occur between governments. The solutions require close, collaborative partnerships between both levels of government. It requires both levels to lead, and if either level of government tries to lay the responsibility on the other, then they will be failing our health system and our community.

4. Any further information

To clarify any aspect of these responses, or any other part of ACEM's submission or testimony, please contact James Gray, Manager, Policy and Advocacy

Yours sincerely

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President

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