First of all thank you for offering me the opportunity to attend the hearing. Secondly, I welcome the opportunity to answer the supplementary questions. However, I would like to make some generic comments in addition to these answers, as there have been some points that have come up during the hearings I would like to clarify.

Firstly to talk about the NDIS. I probably know more than it is healthy to know about the NDIS. Unfortunately, my son is a complete C4 quadriplegic due to a diving accident and I have been through all of the NDIS planning and funding issues that are now cropping up in this enquiry. Because of my situation, I am also on several ACI committees, such as spinal cord injury committee and the transitional care committee, which deals with children with chronic illnesses and injuries transitioning to adult health care settings.

A consistent complaint about the NDIS is the time it takes to approve care plans and funding. To put this into perspective, an adult sustaining a spinal cord injury is managed at one of the two spinal units, either Royal North Shore Hospital or Prince of Wales Hospital, and after their acute care is complete they are transferred to Ryde Rehabilitation Hospital for further rehabilitation and to wait for their home to be modified to the point where they can be discharged home safely.

It is standard for these patients to wait at least one month for their first planning meeting with the NDIS. These are patients that have been in an acute spinal unit for weeks if not a couple of months. They are already known to the system yet spend a further month in a subacute rehabilitation setting before anyone even talks to them about the possibility of getting a care plan funded through the NDIS. It is also standard for these patients to wait anything up to 18 months to 2 years for everything to be in place for them to go home safely. To put this into perspective, my son Matthew was home within five and half months, mainly because we were treated through the Children's Hospital Westmead at a time when the NDIS was being piloted for children only and we were lucky enough to live in one of the trial areas. The Children's Hospital rehab team were also very efficient and motivated to get everything in place for Matthew.

From my point of view, spinal cord injury patients are easy. They all need a wheelchair, various other standard equipment such as commodes, hospital beds, pressure mattresses, adaptive equipment, and fairly consistent home modifications within the constraints of what is in their home to start with. Yet for these patients, it takes months and months to get this finalised.

For example, 3 years ago Matthew needed a new wheelchair. He had grown out of his first wheelchair, having been injured at age 14. We also asked for a "sit to stand" wheelchair as standing is a very important part of spinal injury patients ongoing rehabilitation and has significant acute and chronic health benefits. From start to finish, the approval process took 2 years. It would have taken

longer if not for a particularly helpful and aggressive planner at the NDIS who took on Matthew's case and make sure everything was approved.

The standard obfuscation strategies used by the NDIS include initially denying the plan, asking for more reports from occupational therapists and physiotherapists, the application taking so long that the initial quotes are out of date and more quotes are needed, the application then being processed as a new application because of the new quotes, and because of the new quotes more reports from occupational therapists and physiotherapists are required. For his wheelchair that took two years to approve, we submitted three occupational therapist reports and were asked for new quotes twice.

This is magnified in hospital. A lot of the more difficult NDIS claims relate to behavioural issues, such as brain injury, stroke, early onset dementia and cognitive decline, and mental health type issues. Quite often we recommend that a patient can only live in a home situation where there are two NDIS participants due to behavioural reasons. Our experience is that the NDIS never approve this situation, and usually approve accommodation of at least three participants, usually to save costs through economy of scale. What happens first of all is that this patient stays in hospital longer than they should when the initial NDIS application is refused and further reports required, with the possibility of engaging an appeals process. Second of all, these patients often go home with what the NDIS have approved anyway, for example going to a group home of three participants rather than two, where they are unable to cope, develop a crisis situation and present back to hospital as their home environment is unsafe. They then stay again for a prolonged period, in part because of a reapplication to the NDIS for increased funding.

It is bizarre that there is no one from the NDIS working in acute public hospitals. You have heard through testimony that there are a great number of patients in acute hospital beds awaiting NDIS approvals and placement. It would make perfect sense that someone would be on staff at the hospital specifically to facilitate the approval process for these patients. Hospital occupational therapists, physiotherapist and rehabilitation physicians would all be part of the process but there would be someone controlling the process centrally working in the hospital to facilitate the process.

What is not appreciated is the fact that the NDIS is pulling resources from public hospitals into the community. This is especially seen with nursing staff and with allied health, such as physiotherapy and occupational therapy, mainly through the large pile of money that is being poured into the community to look after our most vulnerable. Firstly these patients now get the assessments that they always needed but couldn't get because of financing. The people performing these assessments are physiotherapists and occupational therapists and now their workload is increasing, the deficit is seen in the public hospital system with these therapists leaving to join private practices. Secondly, an enormous number of carers are required for the disabled population. Nurses are leaving the

public hospital system to satisfy this need, often for better wages and significantly better conditions and work environment than in the public hospital system. As the NDIS moves to full capacity that is required for the number of the disabled in the community, the impact on public hospital staffing will increase. The obvious solution to this is to train more nurses, satisfying both the need of the NDIS and the deficit currently and forecasted in the public hospital system.

I would also like to comment on the so-called cost of treating a patient in the emergency department. The number bandied around approximates $500 per patient. This number is complete fallacy. It is dependent on looking at how much it costs to run an emergency department, for example the yearly budget, and dividing it by the number of patients that present to the ED.

There is a minimum cost required to run an emergency department. You decide how big it needs to be, and then you equip and staff it appropriately. Additional patients do not add to the cost of the emergency department except for the use of consumables, for example blood tests, x-rays, medications, dressings, or any other item you may use to treat a patient.

There are medications that cost greater than $500. Thrombolysis, so-called blockbusting drugs that we use for strokes and heart attacks, routinely cost hundreds of dollars. A trauma patient presents and needs a whole body scan, namely head, neck, chest, abdomen and pelvis, each one individually costing hundreds of dollars.

On the other end of the scale, my intern sees a patient with back pain who I then also review. My intern is already on shift and will get paid a salary whether he sees this patient or not, indeed if this patient presents or not, as am I. This patient will receive no x-rays, no blood tests, some Panadol and Nurofen, maybe some endone if they have severe pain, are observed for an hour or two and discharged if the pain settles with referral to a physiotherapist. In the scheme of things, the treatment has cost a view cents. You can buy a box of 100 paracetamol for $3. Any article that suggests reducing low acuity patients presenting to emergency departments will save hundreds of dollars per patient, is overstating the case.

I made comments in my submission about the hospital system's need to balance the workload of emergency medical admissions and elective surgery. Much is made of the fact that hospitals are full during winter and elective surgeries difficult at this time because of hospital capacity constraints. This leads to reductions of elective surgical workload, including cancelling elective surgical lists at short notice. This is also where ambulance ramping and access block is at its worst, which again reflects excessive demands on hospital capacity.

On the other side of the coin, hospitals actively close beds during summer because of the reduced demand on hospital capacity. This is largely a cost-cutting measure, as we still routinely have 20+

admitted patients at 8 AM each day waiting for a ward bed, rather than using the excess hospital capacity during these times of the year to empty out the ED. There is also a reduction in elective surgery during these times. This does make sense in part: patients do not often want their operation during Christmas.

Surely it would make sense to try and smooth the demand on hospital capacity through the year so that the hospital could operate on a fixed number of beds and allow confidence and consistency in hospital funding and therefore staffing. You would use the elective surgical component of hospital activity to smooth out these demands. When winter has hit and the hospital is full, you would reduce elective surgery to allow the hospital capacity to empty out the ED, and prevent ambulance ramping and access block. When the acute medical demand subsides through spring and summer before increasing again the following autumn, you would increase elective surgery to use the seasonal excess capacity in the hospital. By reducing the elective surgical workload during winter, you would also increase the capacity to cover staff sick calls, which also increase in winter, and allow capacity for staff leave during times of stress and excess workload, and would include the July school holidays, also a time of peak leave demands.

It must also be remembered that the elective surgical workload does not necessarily need hospital inpatient capacity. You can still do operations during winter if you decide to reduce the elective surgical bed base. There are a number of operations that can be performed as a day stay procedure. These are often minor procedures that are usually category 3 on the surgical waiting list. However, these are the procedures that wait the longest as they are continually bumped by category 1 and 2 patients. You can also do more of these smaller procedures in a single list compared to longer operations that need hospital inpatient stay, which would accelerate the reduction of the elective surgical waiting list, an important KPI.

There are operations that must be done urgently and I'm not talking about ceasing this activity during winter. For example, the standard of care is that cancer is to be diagnosed and managed within a three week period, and this includes any tumour resection that is deemed indicated, for example mastectomy for breast cancer. Cancer surgery, as well as other surgery for urgent conditions, continue to be performed during Covid lockdowns.

Unfortunately, from the point of view of an emergency physician of 20 years standing, it seems that the emergency department is used as a cost saving measure for the hospital. The hospital seems to tolerate the fact that we have 20+ admissions in the ED at 8 AM waiting for ward bed and tries to perform as much elective surgery as the number of theatres allow. When the winter surge subsides, inpatient beds are closed and the 20+ admissions in the ED at 8 AM waiting for ward bed continues, again with the maximal amount of elective surgery performed. Then over summer, theatres and

outpatient clinics close down, more inpatient beds are closed, and the emergency department is expected to look after all of the patients that present, including patients that wouldn't presented if outpatient clinics were open, exacerbated by the fact that most GPs close down over Christmas as well and that the emergency department is a one-stop shop for any patient who cannot get into a more appropriate health practitioner. We jokingly refer to the period between Christmas Eve and the last public holiday after New Year's Day as our 12 days of Christmas as this is how long we get smashed for with excess numbers of usually low acuity patients because of everyone else being closed over the Christmas break.

This is all largely a function of how New South Wales health approaches the performance of public hospitals. There are three broad categories of performance: elective surgical performance and reduction of the waiting list; emergency department performance; and performance with regards to the budget. Nepean Hospital is on a government watchlist for all three. Unfortunately, we can't solve all three at the same time as they are largely mutually exclusive. The more operations you do, the more inpatient capacity you require, the more money you spend, the worse access block becomes, and the worse emergency department performance becomes.

The hospital consistently runs over a 100% capacity and the only way we can save money is by closing inpatient beds. At Nepean, there is an approach to reduce the elective surgical waitlist as much as possible, to the detriment of emergency department performance. However, the fact that we are on a government watchlist for all three broad categories suggests that we simply do not have enough money and capacity to deal with the workload the hospital was built for. If we increase the budget to create more hospital capacity, we would be able to do more operations, have less access block and therefore improve emergency department performance, and would have no budgetary issues as we would have the right amount of money in the first place.

1. In addition to your testimony, can you please explain why hospitals patient examination on an ambulance stretcher is difficult?

The difficulty examining a patient on an ambulance stretcher relates to several factors. First of all the location of the ambulance stretcher. The patient is unable to be offloaded because there is nowhere to offload into. Therefore, the patient sits in the ambulance bay, usually next to other ambulance patients, as it is usual for ambulance patients to pile up in the ambulance bay when ramping becomes an issue. At Nepean Hospital, the ambulance bay often has 5 ambulance stretchers placed in a confined space to the point where these ambulance stretchers are often only a couple of feet apart. It is therefore difficult just to get in next to the stretcher to perform any kind of appropriate examination.

There is therefore also no privacy as these patients are within full view of each other, as well as being in view of the 8 to 10 paramedics that are present looking after patients, any other patients that are in the ambulance bay or triage area, any other staff working in the area, the psychiatric patients that are in the safe assessment room adjacent to the ambulance bay and the security guards that are looking after these patients. The front door of the ambulance bay is also a massive glass sliding door with glass panels on either side in full view of the ambulance parking bay outside. On top of this, these doors open frequently leading to a significant breeze, which is either very cold in winter or very hot in summer. There are also other multiple patients and relatives moving through this area at any one time.

The ambulance stretcher itself is not conducive to a decent examination. It is narrow and uncomfortable and difficult to position a patient appropriately. For example, for an abdominal examination, you need the patient lying perfectly flat with the abdomen exposed, preferably from the nipples to the pubic bone. Ambulance stretchers are difficult to position, and very hard and uncomfortable for patients, so it is common for patients to not be able to tolerate lying flat for more than a couple of minutes. To examine the chest, you need to sit the patient forwards, again with adequate exposure, for example exposing the anterior chest completely to auscultate the heart. You would not do this in the ambulance bay on any female on an ambulance stretcher.

Because of all the factors I've discussed above, simple procedures such as an ECG or blood tests are also difficult, and x-rays and CTs are virtually impossible as they required the patients going down to radiology on the ambulance stretcher itself. In all, the assessment and management of these patients is severely compromised until they are finally transferred into an appropriate bed space in acute care.

2. Does inconsistent admission and discharge protocols across hospitals in NSW impact on access block?

I can't comment on what other hospitals across New South Wales are doing with respect to the discharge protocols. However, there is a lot of work around admission protocols which I will discuss.

Unfortunately, a lot of the admission protocols that have been written across New South Wales hospitals, and specifically by emergency departments, reflects the situation that inpatient consultants are not keen to admit patients under their care. I will go into the reasons behind this below. However, because of this situation, we have developed the concept of the "contested admission," where there is conflict between various inpatient teams regarding the appropriate treating team for the admission.

For example, a patient will present with shortness of breath. The emergency department decides the patient needs admission and the cause of the shortness of breath is heart failure. Therefore the emergency department calls a cardiologist on call to admit the patient. The cardiologist doubts the diagnosis, suggests that the cause of the shortness of breath is caused by a respiratory condition and asks the patient to be admitted under the respiratory team. On calling the respiratory consultant, they agree with the diagnosis of heart failure and ask that the patient be admitted under cardiology. You then make a third phone call to admit the patient under cardiology, at which point they usually but not always accept the admission.

At Nepean Hospital, it is supposed to be a single phone call admission protocol but as you can see, and in fact quite commonly, it turns into a three phone call admission protocol. There is also the situation where even with the third phone call, the destination team for admission still refuses to accept the patient. Most admissions policies have this situation built into the protocol. At Nepean Hospital, the in-charge emergency physician on duty, or on-call overnight, has the final say on which team is to accept the patient. However, in certain situations this decision is not made and the patient is left overnight in the emergency department with no admission and no inpatient treating team. This is the result of a variety of factors: firstly, it may be a particularly complex patient that is being sorted out late at night, for example close to or after midnight; in combination with the fact that the emergency physician has spent all shift arguing with consultants about admissions and just cannot fight one last battle. Also, it is difficult for an emergency registrar overnight to institute this policy when they are talking to inpatient consultants: they are always going to doubt the initial assessment and diagnosis if the consultant they are talking to suggests tacitly that they are wrong, and they will try and do whatever the inpatient consultant says as they trust their opinion and assessment.

I can understand why inpatient teams are reticent to admit certain groups of patients. Hospital inpatient length of stay is a significant KPI in the hospital system, and inpatient teams are often beaten over the head with it if they are underperforming compared to their peers. Each individual inpatient service also has a limited bed base, and they are beaten over the head if they exceed their bed base, and continue being asked how they are going to discharge patients to get below the bed base. Also there are inpatient services that use their bed space to perform procedures, for example elective surgical teams for operations, gastroenterology teams to do scopes, respiratory teams to do bronchoscopies, and the like. Therefore, there are a lot of reasons why consultants are reticent to accept unwell patients from the emergency department. Perversely, in the emergency medicine community we cannot understand the concept of “not wanting the patient” when they trained to be doctors in the first place!

Obviously, any conflict over the destination team of admitted patients will delay the transfer of that patient to the ward, often by several hours and even, as alluded to above, overnight. Any delay of the transfer of patients to the ward will increase access block and therefore contribute to ambulance ramping. What we need is a change of culture in hospital where inpatient consultants are not penalised for accepting patients for admission from the ED, in the form of restrictions of the practice when they go over their bed base and continual micromanagement from administration to determine when and how they are discharging their patients, especially in the case of patients requiring aged care residential accommodation or NDIS planning, which is largely out of their control.

When talking about discharge protocols, the underlying question is about criteria led discharges. New South Wales health and the ACI have done a lot of work regarding criteria led discharges. Unfortunately, what is not well understood, is that criteria led discharges work very well for elective surgical patients but do not work well for unstable medical patients admitted to the emergency department.

Elective surgical patients arrive at the hospital in full health - generally they would not get an operation if they weren't. They start off well, they get an operation and are ready to go home when they are adequately recovered from this operation. It is quite easy to institute criteria led discharges for these patients.

When you are trying to introduce criteria led discharges for unstable medical patients admitted through the emergency department, based on the work you have done on discharging elective surgical patients, you are largely comparing apples and oranges. Unfortunately, having seen it work for elective surgical patients, one simply assumes that the physicians are not doing their job properly, rather than the problem being with the concept of trying to discharge unstable patients with an unpredictable clinical course based on discharge criteria which are generic and lack any kind of evidence base.

For example, let me talk about a patient with pneumonia. When are they well enough to go home? Firstly we admit patients with pneumonia because they need oxygen. However, to put some medical jargon in the submission, at what level of oxygen saturations are we going to be happy to discharge this patient with. Normal healthy people should have oxygen saturations of 99%. Usually when oxygen saturations drop below 91% the patient is deemed to require oxygen. So what number are you going to pick for criteria led discharge? 91%? 95%? 98%?

We also discharge these patients when they do not require intravenous antibiotics and can be converted to oral antibiotics for discharge. There is no set of criteria that allow us to come to this decision and it is largely based on the clinical Gestalt of an experienced practitioner, namely a

senior registrar or inpatient consultant. Also, do you discharge the patient on the day they are converted to oral antibiotics or do you want to watch them for 24 hours to make sure they don't deteriorate and require intravenous antibiotics again. Unplanned return visits to the hospital after discharge is also a KPI that is used to beat inpatient teams over the head with, so they much prefer to keep a patient 24 hours longer than might be warranted to avoid the predictable return of patients returning to the ED after discharge.

There are very good discharge strategies and protocols in place at Nepean Hospital. The cardiology department have a single person designated the duty cardiologist, separate to the on-call cardiologist and the interventional cardiologist, who is responsible for the final decision to discharge patients on the cardiology service. Every patient is seen every day, but not necessarily by their treating consultant. Therefore, if a patient is potentially ready for discharge on a day that the treating consultant does not do a ward round, that discharge may be delayed a day or two purely because the inpatient consultant has not made their final assessment. The strategy employed by the cardiology department mitigates around this as there is a senior cardiologist on duty primarily for this reason and patients are discharged on the day they are ready for discharge, independent of when their treating consultant performs their ward round.

This has worked so well at Nepean that we are aiming to introduce it for many of the large inpatient services. However, it can only be introduced to services with a large number of staff specialist physicians. Staff specialists are employees of the hospital and are on-site when they are on duty. They are therefore available to review individual patients for discharge at short notice if required. Visiting medical officers perform the majority of their practice outside of the public hospital, namely in their private rooms or at private hospitals. Therefore, they are not usually available at short notice to review individual patients for discharge.

A significant factor influencing the discharging patients is the availability of allied health staff in the process of discharge planning, particularly for the elderly and those patients with poor mobility. Because of the ageing population, this problem is growing. There are a large number of patients that require assessment and intervention of their mobility to ensure they are safe for discharge. Because of inadequate staffing and resources related to allied health, these assessments and interventions, and therefore the patients' discharges, are delayed.

To prove this point, we have a specific geriatric service located in the emergency department specifically designed for discharge planning, including mobility assessments and interventions. This has reduced the number of geriatric admissions due to poor mobility and is an effective and useful service. Therefore, resourcing allied health services appropriately can reduce inpatient length of stay and reduce access block.

3. Has high levels of bed access block had any impact on your resuscitation capacity?

Yes.

I would like to tell you a tale of two hips. Two patients on different shifts, both with a dislocated hip and both with very different outcomes based on the state of the ED and the degree of access block and ambulance ramping.

I won't give the exact dates due to patient confidentiality. There was a week just before the ramping enquiry public hearings when I worked a Wednesday and a Friday starting at 7 AM. On both mornings, on arrival to work, I became aware of a patient with a dislocated prosthetic hip that required relocation. In the scheme of things, this is a minor procedure requiring minimal anaesthetic and the relocation usually only takes a total of 10 to 15 minutes.

On Wednesday, in the three resuscitation bays, there was a patient in significant respiratory distress requiring non-invasive ventilation and was too unstable to go to the ward, a second patient was haemodynamically unstable with significant bradycardia requiring a pacemaker and was on special medications to increase heart rate and blood pressure, again unable to go to the ward, and a third patient with severe sepsis and septic shock requiring significant resuscitation with intravenous antibodies and fluids and was on the cusp of requiring to go to intensive care. There were also multiple ambulances yet to be offloaded into the acute care area because of significant access block in the hospital. When approached by the orthopaedic registrar to relocate the hip, I told him there was no way we were going to be able to reduce the hip in the ED anytime in the next few hours, most likely not at all during the day shift, and that the patient needed to go to theatres for the procedure. The patient was admitted, sat in the ED all day waiting for the procedure, went to theatres at 3 PM that day, was recovered on the ward and went home the next day after physio review and mobility assessment.

On the Friday at 7 AM, there were two resuscitation bays empty and no patients on ambulance stretchers waiting to be offloaded. The third patient in the resuscitation bay was stable and was only there waiting for an acute care bed as there were none vacant at that time. I asked the treating doctor overnight to call the orthopaedic registrar and tell them that if they want to relocate the hip, they need to come straight down because we can do it now. I arranged for the patient to be transferred into the resuscitation room. The orthopaedic registrar duly arrived within a few minutes, and we reduced the hip in the emergency department, finishing before the 8 AM handover. The aged care assessment team did a physio and mobility assessment on the patient, deemed them safe for discharge, and the patient departed the ED for home at 3 PM.

You can see here a significant example of the same patient on 2 different days getting two very different standards of care, with access block being a significant contributor to delayed and therefore substandard care. Also this proves the point that access block begets access block: I was not able to treat the first patient in the ED so the patient had to be admitted, therefore increasing access block and patient delays. Whenever I have an empty ED, I can do my job properly and patients get good care. Not only that, part of the function of the ED is to manage inpatient hospital capacity by admitting the right patients and discharging the patients that do not (or shouldn't) require hospital inpatient care, and we need an empty ED to facilitate this as best we can.

Overall, having all three resuscitation bays full of patients is standard, and is a result of access block causing an inability to transfer acute care patients to the ward, with the lack of beds leading to patients staying excessive length of time in the resuscitation bays. We will get a phone call from ambulance on the "bat phone" advising us of a cardiac arrest or similarly unstable patient on their way and arriving in a few minutes, and we have to decide which of the patients we will move out, as often they will be fairly unstable, in addition to having to juggle acute care beds to make the space to move them out in the first place.

In addition to this, we will have the situation where the three resuscitation beds are full, all 21 acute care beds are full and there are a number of ambulance stretchers yet to be offloaded. Often, we will have more than three unstable patients that we need to place in the resuscitation bays. In this situation, we have to decide which patients are the most unstable and should get preference. On top of this, patients will deteriorate either on an ambulance stretcher or in an acute care bed and we will need to juggle patients between the three areas to make sure that the sickest patients are in the resuscitation bays. In this situation, we are compromising care by placing unstable patients in the acute care spaces and mitigate this by placing them in acute care spaces that are close to the staff base so the senior medical and nursing staff can keep an eye on them on top of the care that they are getting from the general ED staff.

4. Have there been instances where a critically ill patient has needed to be moved out of the resuscitation bay prior to them being stable?

Yes, and this is virtually a daily occurrence. It is routine that the resuscitation bays are full, often with unstable patients that we would prefer not to move out. I have given examples in the previous question regarding situations where we have to attempt to move unstable patients out of resuscitation bays and again, we are simply responding to a disaster type situation where the number of critically unwell patients exceeds our bed capacity to manage them.

5. Will Urgent Care Centres help to address access block?

No. As I stated in my original submission, GP type patients do not clog up EDs and they do not cause excessive ambulance ramping.

Access block is caused by a lack of inpatient capacity to cope with the number of admissions to hospital, sourced from both the elective surgical workload and emergency department admissions. The target population that urgent care centres would be designed for do not require admission to hospital. Emergency departments already cope with these patients very efficiently, as they are resourced to do so. As alluded to earlier in this submission, they also do not cost a lot of money to the emergency department - we have already built and staffed the ED for projected patient presentations and any additional patient will simply cost the price of consumables.

The type of patient that urgent care centres will be able to treat do not occupy a bed space in the ED, would spend a great deal of their time in the ED in a waiting room, either the external waiting room waiting to be seen or an internal waiting room associated with the area of the ED they are being seen in, have their treatment completed within a few hours and invariably go home after treatment. By definition, if this patient required an admission to hospital, they are not appropriate for an urgent care centre.

What is not featured in the debate about urgent care centres is the question of who is going to staff them. We have already identified shortage of nurses in the state and the public hospitals are understaffed because of it. We have also identified shortage of GPs in the community with more retiring than are being trained at the present time. Emergency departments in the state are staffed by a significant number of non-emergency trained doctors, who have gravitated to the emergency department because they are either undecided on their future career path and emergency medicine tends to be the only discipline where undecided junior doctors can be employed, or because they do not want to undergo any kind of training and prefer to work in the emergency department because of work-life balance and because emergency medicine does tend to be an interesting and rewarding place to work, overwhelming workload aside. Opening urgent care centres would only exacerbate these shortages: nurses would leave the public hospital system to staff them, the shortage of GPs would be exacerbated with fewer numbers to look after the chronic and complex patients in the community and emergency departments would also suffer with the loss of significant numbers of non-emergency trained doctors who would potentially staff these practices. Currently, there is not the staffing excess to open new urgent care centres in addition to the available public hospital emergency departments and you would be robbing Peter to pay Paul, so to speak. Considering EDs are highly efficient places for these patients' care, money would be better spent elsewhere, for example, with respect to access block, opening more inpatient hospital beds.

6. What do you believe are the top three actions a NSW Government can undertake to reduce ambulance ramping and access block in Emergency Departments?

Based on what I have given in my original submission and in this submission, I would like the enquiry to focus on the following three actions.

1. Have a more sophisticated approach to elective surgery workload. We cannot be in the situation where a hospital is getting smashed over winter yet tries to do as much elective surgery as it usually does over quieter seasons of the year. The elective surgical workload must increase and decrease based on other workload in the hospital, usually dictated by the number of patients admitted through the emergency department. Do less operations in winter and more operations in summer. Keep hospital beds open to facilitate this rather than closing them as a cost cutting measure and using the ED as an extra ward for admitted patients.
2. Have NDIS and age care discharge planners employed within the hospital system specifically to deal with these patients. Currently discharge planning for NDIS or aged care patients is covered by existing systems in the hospital, usually the geriatric team. NDIS planning and applications requires a specific skill set. Patients cannot be waiting one month for an external planner to come to the hospital to start the process. These patients need to be identified as early as possible and the NDIS planning commenced at a commensurate time by someone trained and skilled in the process and who is employed in the hospital system.
3. Report the KPIs associated with access block and make them publicly available. The time to be seen by a doctor KPIs, as well as ambulance offload KPIs, always make the media as there are a number of hospitals who perform poorly in this regard. However, as I said in my opening statement at the enquiry, these are usually Western Sydney hospitals with poor community resources, and significant access block and ambulance ramping. We cannot see patients in a timely fashion in a full ED with the majority of patients in the waiting room without a bed space to be assessed in. The following must be measured and reported publicly as KPIs: the daily proportion of admitted patients waiting more than 4 hours, more than 8 hours and more than 24 hours for a ward bed; and the number of admitted patients in the ED waiting for ward bed at 8 AM, with the KPI target for the latter to measures, namely those patients waiting more than 24 hours for ward bed and the number of admitted patients in the ED waiting for ward bed at 8 AM being zero.

   Firstly if you measure it would become a problem which requires to be solved. Secondly, it will give context to the KPIs around waiting times for each triage category - the two are related. Thirdly it will highlight the underlying resources of a hospital, such as the

underlying inpatient capacity - inpatient capacity begets access block begets inefficient emergency departments begets poor emergency department performance. If you give me an empty department at 8 AM each day, then you can blame me for poor performance should it occur on my watch.