Q1. **Can you outline to the committee some real-life stories/case studies and anecdotes about the impact ramping and access block is having on frontline clinicians?**

From Emergency Physicians:

1.

‘Access block is a single most important issue creating burnout amongst our staff. Many of my colleagues have given up waiting for the system to be fixed and have either decreased their clinical time or moved out of the field of emergency medicine entirely. It is contributing to my burnout as well – I’ll probably retire early rather than deal with the daily hassle of access block, which only appears to be worsening.

Access block forces us to do lousy care – with all of our beds taken up by admitted inpatients, the only place we can see patients is in chairs located in the hallways and ambulance bays. In this environment, it is difficult to talk to our patients privately and impossible to sufficiently examine many of our patients - leading to over-reliance on test ordering and frequent missed (or incomplete) diagnosis.

I see several patients a day who require a treatment bed – who are vomiting, in significant pain, or who are just very ill – where I am forced to tell them that they will need to spend many more hours in the waiting room due to the lack of available bed. It seems that I’m always apologizing for the system not having enough capacity to treat people who are very ill. We are all trained to provide excellent care, so it pains me when I have to provide bad care because there are no beds in the emergency department. We weren’t trained to be cruel, but the system forces us to make the harsh decisions every day to keep the people needing our care the most in the waiting room because there are no beds.

There are so many close calls that occur as a result of access block – if only a few more than made it into the paper, maybe something can be done about it. I’ve seen it all – people vomiting into plastic bags in the waiting room, people lying on the floor in the waiting room or across a row of chairs because there is no bed in the emergency department, women having miscarriages in the waiting room and the elderly in wheelchairs who have been parked out in the waiting room waiting for a bed who end up urinating or defecating on themselves.

I’ve had patients requiring admission to the hospital who have had to wait in the waiting room for up to 10 hours simply for a bed in the emergency department to become available – and then remaining in the emergency department for another two days before an inpatient bed on the wards becomes available. The Australian people deserve better.’

2.

‘Maintaining their confidentiality- there are nurses and doctors who have PTSD, some have left the organisation and senior staff are on reduced hours due to burnout and unsupportive administration.

Doctors are forced to take risky decisions and any serious adverse event writes them off for life.’

Q2. **Can you outline how additional hospital outreach programs would help alleviate pressure in Emergency Departments?**

Additional hospital outreach programs will prevent attendances to hospital, particularly from older peoples, as the clinical needs of deteriorating patients can be addressed in the patient's residence.

There are a number of hospital outreach programs, including Hospital in the Home, Virtual Health and Geriatric Flying squad which successfully prevent presentations to hospital from patients in Residential Aged Care Facilities (RACFs), and reduce hospital length of stay by getting patients home earlier. These programs are inconsistently available across NSW and typically under-resourced.

We recommend that every LHD be given an additional amount of funding to ensure a full time medical director, adequate nursing and medical staff to run this service 7 days a week. This will ensure that RACFs are able to access medical staff for an in-person assessment, or access virtual care to assess whether they need to be transported to hospital.

These services also ensure that patients can have end of life plans initiated instead of being transported to hospital (often against their wishes).

Q3. **How does inconsistent admission and discharge protocols in hospitals across NSW impact on bed block?**

Inconsistent discharge policies and processes lengthen patient's stay in hospital. There should be very clear criteria for when a patient is discharged (as per the ACI guidelines) but this criteria is implemented inconsistently across hospitals.

Inconsistent admission policies are not as large an issue, as most hospitals would have roughly the same threshold as to "something needs to be done as the person is too unwell to be at home by themselves" - so this is more likely reflect on the need alternative methods to care for the person other than admission as an inpatient – e.g. hospital in the home, remote monitoring, etc.