Submission No 482

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Dear Committee Members

Firstly, thank you for extending the deadline for submissions, but please, do not see my failure to submit earlier as disinterest. I have worked on the frontline with New South Wales Ambulance (NSWA) for over 40 years now, mainly in country NSW. In that half lifetime, I've seen the sadness wrought by NSWA's indifference towards country people. Had I not had an old defibrillator at home when my wife had a cardiac arrest, I'd be part of that sadness. Doing CPR and shocking her while waiting ½ hour for an ambulance was terrifying. The MoH too needs to realise that to satisfy its obligation to provide equitable access to hospital services *regardless of a person's geographical location,*[1] it must equip its country paramedics with higher skills sets.

[1] National Health Reform Agreement: Addendum 2020 – 2025 - clause 8 Medicare Principles (c)

Now however, and for several years now, as that 50% of higher trained paramedics retire, they are being replaced by base trained ones. This means even the benefit country people received from the sheer number of higher trained paramedics has been eroded. In many towns now, often ones a long distance from a major hospital, there are no higher trained paramedics.

The introduction of ALS training to country paramedics was initially prompted by calls from the Royal Australasian College of Surgeons to do something about the death rate associated with trauma in country NSW (where there were no ICPs or higher trained paramedics).

It evolved following broadly the recommendations of past public inquiries and addressed the concerns they raised in relation to equity and universal access to higher skilled paramedics. These reports are still available in the State and the Parliamentary Libraries – as is no doubt in the NSWA *Future Directions Report 1992* in which the plan to train all to ALS – Advanced Life Support was published– making it the new base level for paramedics across NSW.

Out of Hospital Cardiac Arrest - TOR (b)

The crude incidence of Out of Hospital Cardiac Arrest (OoHCA) is much higher in country NSW (130 per 100,000) compared to metropolitan NSW (84 per 100,000). [2] Whether this is because primary health care by GPs is less available or specialists such as cardiologists are less accessible is unclear. What is clear, is that notwithstanding the incidence of OHCA is 55% higher in country NSW, the treatment NSWA now allows its country paramedics to give to patients in cardiac arrest is much lower to that it makes available in metro NSW via its network of Intensive Care Paramedics.

The fact is, if they are to have any chance of surviving - a person suffering an out of hospital cardiac arrest in country NSW - in Blayney for example – needs the exact same drugs and procedures as a person in cardiac arrest in the Sydney CBD – and they need the just as quickly! Yet - despite the incidence of OHCA being 55% higher per capita in country NSW – and tertiary hospitals being much further away - NSWA thus has deliberately maintained a system in which country people are denied a level of care comparable to that provided in metropolitan NSW where tertiary hospitals are nearby.

I respectfully submit, this disgraceful chapter in NSWA history must be set right.

[2] NSW Ambulance Cardiac Arrest Registry 2018 Report. P 15.

Test of any Proposal

In your review, please consider applying this test to any proposal or response by NSWA. Ask yourself – is this proposal bullet proof? Will it ensure, that no matter what, seriously ill patients in country NSW will receive the highest level of care that can be reasonably expected (i.e. is at least similar to ICP) with the arrival of the first ambulance on scene, **OR does it maintain ICP elitism by keeping a significant gap between ICP and everyone else or keep the number of ICPs smaller than other options (maintain elitism)?**

The Merit of Abandoning ALS Training for Country Paramedics - TOR (c)

The fact is, while we once had 50% of country paramedics trained to ALS, as those now older ALS paramedics reach retirement and are replaced by P1 paramedics, the seriously ill people in smaller country towns are increasingly denied access to higher skills because unlike ALS – P1s inter alia, are NOT authorised to:

1. **Sedate patients** for painful procedures like straightening a broken leg. ALS paramedics will use Ketamine or Morphine and Midazolam to put patients to sleep – into a twilight zone while doing such things. The patient may still feel the pain and respond – but not remember it – so it didn't happen, if that makes sense. I contend it is a fundamental human right to not be forced to endure and remember avoidable extreme pain.
2. **Give Atropine** when a patient's heart is beating too slowly. A heart beating too slowly can cause blood pressure to plummet and the patient go into cardiogenic shock. These patients will often need an emergency pacemaker – but atropine can buy time for that to happen.

3. **Give Adrenaline** where atropine has failed – where atropine doesn't work the patient can be in dire straits. If they are a long way from hospital you can expect them to die if they can't have adrenaline to support them.
4. **Give Adrenaline** to maintain patient's blood pressure and heart rate after cardiac arrest. After resuscitation from cardiac arrest the patient's heart can be very unstable and needs support till it settles. A Pt who needs post ROSC adrenaline can be expected to die without it.
5. **Give Frusemide** – a diuretic used in severe heart failure where fluid is building in the lungs preventing oxygen getting into blood (pulmonary oedema). With this drug a person who on arrival is drowning in their own lungs can be pulled back from the brink and within 15 – 20 minutes speak freely enough to offer heartfelt thanks for your intervention.
6. **Establish intraosseous vascular access** in seriously ill children. It is notoriously difficult to insert an IV in some children. To have the intraosseous route as a fall back in dying kids can be lifesaving.
7. Perform **emergency thoracostomy** in case of tension pneumothorax (collapsed lung to relieve deadly pressure build up). These patients are not encountered a lot but when they are – this procedure is the only thing that will stop them dying.
8. **Give Oxytocin by IV** drip in post-partum bleeding. Women who bleed after child birth bleed a lot. When you are a long way from a hospital able to deal with it – it is terrifying - believe me. I had a young mother who lost around 3 litres of blood. We were an hour away from a hospital that could manager her and she probably only had another couple of litres left! She lived but it was terrifying.

9. **Give Ketamine** in brain injury or behaviourally disturbed patients. These patients can be very difficult to manage. Their brain is damaged by bruising, bleeding or swelling causing cerebral irritation. To manage their other injuries, one often must sedate them. Other drugs can be used in a pinch but Ketamine is best.

Advanced Life Support – Artificially Different to ICP

While Advanced Life Support (ALS) does not equip paramedics with every drug or procedure found in the Intensive Care Paramedic (ICP) armamentarium, it equipped us with the most commonly used, most beneficial and essential drugs and procedures in that armamentarium. So much so that it prompted the then Medical Director of NSWA to describe the distinction between country-based ALS and metro ICP as an *"artificial distinction"*. [3]

It is vital to note that any perceived inferiority in ALS compared to ICP must be weighed against the fact all country paramedics – not just some – were to be trained to ALS. This approach overcame the key obstacle to equity in country NSW - the tyranny of distance. Had that policy been seen to completion, it would mean regardless of their geographical location, seriously ill patients in country NSW would be provided a level of care artificially different to metropolitan ICPs immediately the first ambulance arrived.

The fact is, if they are to have any chance of surviving - a person suffering an out of hospital cardiac arrest in country NSW - in Blaney for example – he or she needs the exact same drugs and procedures as a person in cardiac arrest in the Sydney CBD - and they need them just as quickly. They can't wait for a "strategically located ICP" to come from Orange or Bathurst. The first arriving ambulance needs to be able to provide that patient

with whatever he or she needs there and then. This was recognised by inquiries as far back as 1982 when the Gleeson Inquiry proposed NSWA consider abandoning its ICP system because it is not universally available and instead – train all paramedics to a level in between base level and ICP – just as the inaugural Board intended when it set policy to train all to ALS.

In fact, in the 30 years I have practiced as an ALS Paramedic I am comfortable saying there are really only two drugs and one procedure which need to be added to the ALS scope of practice- that is Amiodarone, Lignocaine and endotracheal intubation.

Mechanical CPR

There are of course a number of other procedures which have since been developed and have increasingly found their way into paramedicine and need to be introduced across the board. This includes mechanical CPR (mCPR) and intraosseous cannulation in adults via a drill.

In mCPR an indefatigable machine is attached to the patient's chest and it does the chest compression part of CPR. This best ensures high quality chest compressions are maintained. It also releases the paramedic who would otherwise be on the chest, to attend to the many other vital interventions the patient needs if they are to have a chance of surviving.

However, did NSWA introduce these devices to country NSW first – where the crude incidence of OHCA is 55% higher or did they offer it to metro NSW first? Of course it introduced them in metro NSW where between four and six paramedics often arrive on scene within moments of each other – the per capita incidence of OHCA is lower and tertiary hospitals with cardiac catheterisation labs are a stone throw away. Such is the disinterest NSWA shows to country NSW.

If they introduced them to country NSW the machines would immediately turn a crew of two into a crew of three and give the patient a chance because it releases the paramedic on the chest to attend the many other things that need doing if the patient is to have a chance. It also prevents the team of two becoming exhausted because there is insufficient paramedics on scene to share the time on the chest. Performing chest compressions is fatiguing and studies show operator fatigue leads to compressions which are too shallow or too slow within a few minutes. When there are just two of you on scene for 30 minutes or more before back up arrives a couple of minutes off the chest to "rest" is insufficient to recharge because you are too busy doing other things. Two people simply cannot maintain effective CPR for half an hour without becoming fatigues. It is in country NSW that we need indefatigable chest robots to do the compressions and release paramedics from that task and thereby turn a crew of two into a crew of three – but no – mCPR devices are given to metro NSW.

The same has happened with intraosseous vascular access. Drilling into a bone to get intravascular access went to Metro and is not available to country paramedics. In a cardiac arrest in country NSW where backup is a long time away the crew of two are forced to focus on doing the best quality CPR possible and don't get time to put a drip in to give adrenaline etc. By the time back up arrives it can be very difficult to find a vein to put a drip in. The problem here is veins collapse and disappear as blood pressure drops – and it plummets to zero in cardiac arrest – so by the time backup arrives there may be no veins to find.

This is where intraosseous access becomes a necessary alternative if the patient is to have a chance - no veins – no problems - drive a needle into the bone and get drugs into the blood stream that way but no – metro paramedics get it - where between four and six paramedics often arrive on scene within moments of each other so there is no time for the veins to collapse, the per capita incidence of OHCA is lower and tertiary hospitals with cardiac

catheterisation labs are a stone throw away. Such is the disinterest NSWA shows to country NSW.

Studies have shown intraosseous access can be gained in around 15 seconds,[4] and can be taught in as little as two hours,[5] yet NSWA has chosen to reserve this life saving procedure to ICPs in metropolitan NSW. Again NSWA shows its disgraceful disinterest in country people.

Chronology of Relevant Reports and Events

1. **1976 - Intensive Care Paramedics Introduced to Sydney –** The first Sydney based ambulance officers undertook ICP training. Initially there was just one Intensive Care Ambulance crewed by two ICPs located in the Sydney CBD. As more and more ICPs were trained a network of IC cars were strategically stations across Sydney, Newcastle and Wollongong – the areas country people refer to as NSW!
2. **The Gleeson Inquiry – 1982.** For completeness I must point out that when the Gleeson Inquiry was conducted ICP was still fairly much in its infancy. The broad network of ICP stations now spread across metropolitan NSW was not at the level it is today. Thus, Gleeson questioned inter alia, the very worth of the ICP system in metropolitan NSW. He was very concerned that it was not available to all people. This lack of universal

[4] Leidel, B. A., Kirchhoff, C., Bogner, V., Stegmaier, J., Mutschler, W., Kanz, K. G., & Braunstein, V. (2009). Is the intraosseous access route fast and efficacious compared to conventional central venous catheterization in adult patients under resuscitation in the emergency department? A prospective observational pilot study. *Patient safety in surgery*, 3(1), 24. https://doi.org/10.1186/1754-9493-3-24

[5] Sørgjerd, R., Sunde, G.A. & Heltne, J. (2019). Comparison of two different intraosseous access methods in a physician-staffed helicopter emergency medical service - a quality assurance study. Scandinavian journal of trauma, resuscitation and emergency medicine, 27(1), 15. doi:10.1186/s13049-019-0594-6.

availability caused Gleeson to proposed NSWA consider disbanding it and either train all to ICP or instead train all paramedics (then referred to as Ambulance Officers) to the highest level feasible between ICP and the base level.

- The truth is – back in 1980, not all paramedics had the academic ability to train to ICP. Few had completed formal secondary education or had a School Certificate, let alone a Higher School Certificate.
- Since the HSC was introduced as a minimum entry level qualification all paramedics have probably had the academic ability to train to ICP. However, NSWA appears intent on keeping the number of ICPs artificially small.
- Today – paramedics come with three years of university study behind them and hold a bachelor's degree in Paramedicine, all perfectly capable of undertaking the technical training to ICP or even simply progressing to ALS at the end of their period of internship.
- One of the reasons NSWA put to Gleeson as to why ICP number had to kept small was that to maintain their skills and competencies, it was claimed they needed a population of at least 180,000 (but some cited numbers as high as 240,000). Gleeson challenged this by asking which station had the best of the best ICPs and was told Paramatta has the top guns. Gleeson then examined all of the case sheets generated by Parramatta's ICPs. He noted the patients they attended were almost exclusively located in the Parramatta post code. In that era, Parramatta had a population of just 30,000 people – thus Gleeson debunked the claim a high population was necessary to maintain skills.

3. **The Paramedic Report - 1984** this report was commissions after Gleeson proposed NSWA consider disbanding its ICP system due to its lack of universal access and train all to ICP or a level in between. Ultimately, the report recommended that NSWA train all its paramedics to ICP, via a staged process over about 5 years (if I recall correctly) from recruitment. From memory, the stages were – 1) cannulation, fluid therapy and basic drugs, 2) intubation 3) defibrillation, 4) full cardiac drug therapy.
    - In essence, this is the approach ALS training was following. When first introduced in 1985/6 the nomenclature adopted was ILS – Intermediate Life Support. This was consistent with stage 1 above. The next stage was ALS which, taking advantages of technology during the Dot Com boom was able to move stage 3 (defibrillation) forward and make it stage 2 and also bring some of stage 4 into stage 2.

4. **Intermediate Life Support – 1985/6** ALS training started with ILS. Consistent with the first stage of training recommended in the Paramedic Report. It coincided with calls by the Royal Australasian College of Surgeons to do something about the death rate associated with trauma in country NSW where there were no ICPs. This saw ILS training limited to country paramedics (Ambulance Officers) and saw them trained in cannulation, basic drugs and IV fluid replacement in trauma etc.

5. **1988 Public Accounts Committee –** concluded that despite recommendations of numerous previous inquiries, NSWA management were still failing to come to terms with modern management practices. To remedy this, it recommended a Board of Directors be established to direct the affairs of NSWA and a non-clinical CE be installed to manage

its affairs in accordance with the Board's directions. A State Superintendent would operate under the CE.

6. **Advanced Life Support – Circa 1990** – as noted already, advances in technology (advisory defibrillation) allowed the staged training approach recommended in the Paramedic Report to be modified to take advantage of technology. At their first two yearly recertification ILS paramedics upgraded to ALS. Ultimately all paramedics were trained to defibrillate. ALS training itself was still only open to country paramedics. This helped greatly with filling vacancies at less sought-after stations. A younger paramedic who wanted to acquire advanced clinical skills could successfully apply for a posting at a remote or less desirable station, knowing he or she would be fast tracked to ALS. After giving I think two years' service after training, he or she would have greater chances of success in applying for a more sought-after station.

7. **Future Directions Report 1992** In its inaugural report, *Future Directions,* the Board established following the 1988 Public Accounts Committee recommendation set the aim of training every paramedic in NSW to Advanced Life Support, and all new recruits were employed on the condition they would complete ALS training within I think 3 or 5 years.

    - The Board's new direction took advantage of higher entry level qualifications and ultimately saw a blending of Gleeson's concern re universality and training all to a high level and the recommendation the Paramedic Report of eight years earlier of training all to ICP via a staged process.
    - This new policy presented a threat to the elite status of ICPs. It is hard to stay elite when everyone has a similar skill set as you. As the number of ALS paramedics grew in metro NSW the need for backup by ICPs was reduced

markedly. The dual response model where the closest available ambulance was dispatched and backed up with a designated ICP car was still in use but, because base level cars were increasingly crewed by ALS – the IC car backing them up was increasingly called off before they arrived because the ALS paramedic had the skill set to manage the patient without help.

- This was perceived by many ICPs as a threat to their elite status – they were no longer "special" – people's lives no longer depended on them rushing to back others up. Plainly, it might become difficult to justify maintaining a network of designated IC cars spread across metro NSW if they were always being called off. There was of course room for NSWA to raise selected ICPs to an even higher level – but it is unlikely all would need to be trained to that higher level. Hence the threat.
- With the benefit of hindsight, I contend the Board made a fatal mistake when it opened ALS training to metro paramedics. In doing so it threatened the special status of ICPs. That status can only be maintained by keeping the number of ICPs artificially low and competitively sought after.
- In whatever the Committee may recommend, I ask it bears in mind the immaturity of NSWA as an organisation in relation to the need for some to feel special – even as it turns out – if that is at the cost of lives of country people.

Metropolitan v Country Service Delivery Model

Through its network of Emergency Ambulances carrying base trained paramedics (P1s), who can be quickly backed up by strategically located Intensive Care Ambulances spread across metropolitan NSW (Newcastle Sydney and Wollongong) seriously ill patients have both rapid and equitable access to highly trained Intensive Care Paramedics (ICPs or P2s) – and have had it for decades. Where a designated IC car is busy, P1s are backed up by supernumerary ICPs (of which metro has many). These supernumeraries also fill roster and sick leave gaps etc. Medical teams are also strategically located around metro NSW and can be swiftly brought into play.

An additional overlay in metropolitan service provision is that of Extended Care Paramedics to whom emergency crews can refer patients with lower acuity problems. They have a broader training in lower acuity conditions. They can suture wounds, start patients on antibiotics to tide them over to see their GP, reduce dislocations and refer to GP and manage

other lower acuity but higher complexity issues and thus avoid the need for the pt to be taken to hospital.

Things are very different in country NSW. Notwithstanding 50% of country paramedics had been trained to ALS and, notwithstanding all that 50% were offered the opportunity to upskill to ICP if they wanted . As noted earlier, natural attrition is taking its toll and many towns are increasingly finding themselves with only base trained P1 paramedics.

While it is true that, consistent with the *Review of Clinical Services,* NSWA has established designated ICP cars in some regional towns; that is of no benefit to that patient in cardiac arrest in an outlying town such as Blayney, as already mentioned. Waiting half an hour or more for an ICP strategically located at Orange or Bathurst to arrive just won't cut it and medical teams are generally well over an hour away, even by helicopter.

The inescapable fact is – from 1986 – ten years after ICPs were established in Sydney through till 1996, NSWA was rapidly closing the equity gap between country and metro. by training all country paramedics to ALS. While it is true that ALS did not make every procedure or drug from the ICP armamentarium available to country people, the most important were and additional procedures and drugs were being introduced almost on a yearly basis. The *artificial distinction* between ICP and ALS was rapidly closing. Indeed, according to the staff elected director it was the Board's intention to align ICP and ALS such that the distinction would become imperceptible. [6]

This needs to be set right and in the following I offer my thoughts how this can be done based on decades of experience and clinical practice in country NSW and my familiarity with past inquiries.

[6] Personal discussion – Staff Elected Director.

Options to Close the Gap Again – First - What Won't Work

I won't speak too much to metropolitan NSW – it is more than able to advocate for itself. Suffice to say the dual response system works well there. Distance is not an issue in metro and the highly developed network of Intensive Care Ambulances (and supernumerary ICPs) ensures seriously ill patient have rapid access to both base trained paramedics and ICP - often arriving at the same time. It also makes up for the relative inexperience of many P1 paramedic in metro NSW where the average length of service is as low as 18 months v country paramedics, where at my station – average would be – 20 years.

It would be a terrible mistake to believe the metro model will work in country NSW. The tyranny of distance ensures it will not provide equitable access to high level care.

Do not be surprised if NSWA responds with a plan to train half the paramedics at each country station to ICP. It seems there is an unwritten but overarching priority to keep the number of ICPs in NSW artificially low – probably to keep it elite.

Service Provision in Country Towns - TOR (c)

The tyranny of distance makes maintaining ambulance service provision in country NSW problematic. It means for the most part, they must be self-reliant or self-supporting and they often only have one crew rostered on shift. In a model where only half the paramedics in town are trained to ICP – what happens when for example - the ICP goes off sick and a call to a cardiac arrest comes in? The P1 will be sent and control will scramble to find anyone to back he or her up – even if they have to come from another town. Circumstances which happen every day across NSW have conspired to deny that patient an ICP response. There are many problems like that in country towns - rostering - sick leave – annual leave - after hours on call - the sheer finite number of paramedics living in the town.

What happens when all the rostered an on-call crews are busy on cases and another call comes in? I will tell you what happens – control phones around to try to find a paramedic who lives in the town who, while they may be on days off or annual leave even – they might be able to come in and respond because put simply – they are the only paramedic in town able to respond.

Country paramedics are often called in on days off when not on call and it's the only way to cover the call. When this happens (and it happens often) NSWA does not care what level paramedic it gets. It only cares about its KPIs – getting a car – even a single P1 paramedic to the scene within the timeframe required by the KPI. What happens when the crew are loaded with a patient and they are sent to another call in town to "standby" i.e., care for the second patient until a car can be sent to them to attend to and transport the second patient. Both the patient in the back is seriously ill and needs advanced skills and the patient they are standing by at is also seriously ill. Unless both paramedics are trained to the same high level one of patient will get a lower level of care during the 30-60 minute wait for back up.

The only way to ensure equity is to train all country paramedics to a high level so that they can meet all the immediate needs of a critically ill patient as soon as they arrive. Given the tyranny of distance, patients have often had to wait long enough for the first ambulance to arrive especially if the call is some distance from town – and it is not infrequent that the first ambulance has just one paramedic on board. These patients simply cannot wait again for a higher trained paramedic to back the first car up.

By training all paramedics in country NSW to the same high level – capable of meeting the immediate needs of the patient is the only way to do it. As you might imagine – managing a seriously ill patient often involves escalation of treatment strategies – e.g. bradycardia – after initiating all basic treatment (which takes time) one moves to atropine – which takes time - if

fails – adrenaline – if fails transthoracic pacing etc. It all takes time. Provided a medical team or critical care paramedic is started promptly – if the primary response team is trained highly enough - by the time the med team arrives the primary crew are approaching then end point of their scope of practice. The med crew is not then required to start from scratch and go through all the escalation steps on what by now will probably be a dead person. The primary crew have already attempted that and probably kept the patient alive so the med crew can move direct to – for example – inserting a temporary transvenous pacemaker.

Training all is the only way to overcome the tyranny of distance in country NSW and the difficulties it throws up by the limited resources available in country NSW.

Recommendation

Starting in country NSW, follow the basic approach laid out in the Paramedic Report but adopted by the ALS system. Train all country paramedics to ALS – most of which can be completed by remote learning. Then once achieved, transition them to ICP. Graduate interns should probably be to that highest level within two years of recruitment. Then – but ONLY once all country paramedics are trained to ICP or similar, should NSWA look to whether it will take the same approach in metropolitan NSW. Really – I don't care what they do in metro. Influential people live there so it will always be OK.

I contend that it is only by training all country paramedics to a high level can NSWA provide equity and can the State fulfil its obligation to equitable access to hospital services regardless of a patient's geographical location. The fact is – for a person to have equitable access to hospital services – the patient must first survive the trip to hospital. This can only be achieved in country NSW by training all its paramedics to a high level.

I would be happy to speak further to his if it will help the Committee.

The Ministry of Health – Patient Destination Matrix - TOR (c)

In the *National Health Reform Agreement – Addendum 2020-25*, the State of NSW affirmed its commitment to the Medicare Principles.

At clause 8 (c) of that agreement, [7] NSW Health reaffirms its commitment to the third Medicare Principle – Equity – which requires that:

> *"Arrangements are to be in place to ensure equitable access to such services* (public hospital health and emergency services) *for all eligible persons, regardless of their geographic location. "* [8]

I won't speak again to the failure to ensure highly trained paramedics are universally available to country people to ensure they reach those hospital services alive – instead I direct the Committee's attention to what the Auditor General said in relation to this principle in an Audit Report.[9] In discussing this principle the Auditor General noted it does not require the State to ensure every hospital is equipped to provide every type of hospital service, but instead, the State satisfies that obligation by in essence, where necessary, paying the costs associated with secondary transfer to a hospital capable of providing the level of care the patient needs. That is – NSWA billed the hospital for the secondary transfer from the peripheral hospital to the receiving hospital. This arrangement developed in days when paramedics only took patients to the closest public hospital emergency department and if they needed to be transferred to a more sophisticated hospital – the local hospital paid the cost of ambulance transfer.

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[7] National Health Reform Agreement – Addendum 2020-25 Clause 8 (c). Downloaded 15/12/2020 http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

[8] Ibid.

[9] Performance audit report: hospital emergency departments: planning state-wide services / [The Audit Office of New South Wales] section 3.1 Planning Emergency Department Services.

Since then, the MoH has introduced what it calls the *Hospital Destination Matrix*. This matrix directs paramedics to take certain patient presentations directly to a major hospital – often many kilometres away and in doing so – because NSWA charges per kilometre, it takes the cost of what would otherwise be a secondary transfer, paid for by the hospital and shifts it to the patient. This I submit is diametrically opposite to that required under the Medicare Principle of equitable access and it impacts most on country people.

While it may be the case that the MATRIX helps get the right patient to the right hospital the principle of equity demands the Local Health District picks up most of the bill for transport beyond the kilometres the ambulance would have travelled had it taken the patient to the closest public hospital ED. That is – the bill should be split - the patient pays the equivalent of transport to the local hospital and the rest is paid by the LHD. While ever the patient is picking up the whole tab for the failure of a Local Health District to provide a particular service at the local hospital, the LHD will have no financial incentive to provide that service.

Further on "costs" - the Matrix is far from perfect. For example, where I work, the Matrix directs paramedics to take any sick or injured child to John Hunter Hospital – 60 kilometres away – resulting in a bill of $700-$800. Even if the child needs a few stitches for a minor wound which a GP or Extended Care Paramedic (ECP) could manage, we MUST take the child to JHH 60 KLM away at a bill of $700 - $800 because unlike metropolitan ECPs we are not trained in suturing.

If the mother elects to take the child to the local hospital nothing will be said and the child will be treated and sent home. If a paramedic takes the child there, hell breaks loose and we have to respond in writing to formal complaints from the hospital staff and despite our rational will be held to be in the wrong.

On the other hand, the MATRIX tells me I must take patients with abdominal conditions to our local hospital. If I blindly followed that directive I should take a patient with a dissecting

abdominal aortic aneurysm to the local hospital but I won't. If that patient is to survive they need to be taken direct to a hospital capable of the complex surgery necessary to repair it. If, contrary to the MATRIX, I take the patient to JHH – nothing is said. If I took them to the local hospital all hell would break loose because I didn't demonstrate sound clinical judgement.

Recommendation

1. Paramedics need to be allowed to exercise clinical discretion in relation to which hospital they take patients to and not have managers judge us wrong by focusing solely on what the Matrix says and not taking into consideration other relevant factors.
2. The Matrix should be altered so the urgency with which transport to a specialist hospital is considered by paramedics. At present, if the matrix directs to a major hospital the area I work is left without ambulance cover until a car can be sent from Newcastle. Where the is no urgency associated with the patient's condition then leaving a community of 30,000 people devoid of emergency ambulance cover just to satisfy the Matrix cannot be justified and is contrary to the hub and spoke model proposed in the Sinclair Report – Providing Health Services in Smaller Towns.
3. The Committee recommend the MoH change NSWA billing practices to ensure where paramedics take a patient direct to a major hospital – the patient only pays the equivalent of being taken to closest public hospital, and that hospital (or LHD) is billed an amount equivalent to what it would have to pay for secondary transfer had the patient been presented to that hospital.

Extended Care Paramedics - TOR - (c) and (g).

As noted earlier, Extended Care Paramedics have broader training in lower acuity conditions. While lower acuity, these cases can be higher complexity – particularly in the elderly. Their scope of practice allows them to manage a number of conditions consistent with what one might expect from a GP if an "urgent" appointment were available. In saying urgent we are not talking life threatening "emergencies" – we are talking about conditions which can be managed by a GP if seen promptly – before it becomes an emergency – or needs to be seen promptly for humane reasons such as pain. These patients can avoid ED if a GP appointment can be arranged promptly or the paramedic can do what the GP would in the first instance with GP follow up arranged for few days later.

In country NSW GPs are much thinner on the ground because put simply – they can earn as much money working in suburban NSW Monday to Friday 8am – 6pm with no on call and avoid completely the pressure and responsibility which comes with providing medical cover at smaller country hospitals when seriously ill patients are brought in.

If country paramedics are also trained to ECP level they can plainly help fill a gaps found in providing continuity of medical cover in country NSW. Yes nurses do this to a point in country hospitals but the difference is, I contend paramedics receive more training in clinical diagnostics because unlike nurses who tend to work with doctors, paramedics the must make a diagnosis before they can treat the patient.

Recommendation

In country NSW all paramedics should be trained to a level comparable to ICP and have added to their training all of the ECP modules to help relieve the pressure that comes with the difficulty attracting GPs to country NSW and keeping them there.

Supporting this recommendation will, not only help fill gaps in medical cover to towns it will, like when ALS training was only open to country paramedics, help greatly in attracting younger paramedics to country NSW to obtain skills not open to them in metropolitan NSW. A proportion of them will no doubt end up staying.

Paramedics and Post Traumatic Stress Disorder – ECP a Potential Solution

While this may not quite fit the Terms of Reference I submit it can be construed to do so if you read on so I must raise it. Based on four decades on the front-line I must also speak to the part training all paramedics in ECP can play in reducing the incidence of Post-Traumatic Stress Disorder – more precisely - undiagnosed PTSD causing paramedics to kill themselves. I am convinced it is the ONLY way NSWA can do anything to stop or reduce the incidence of suicide amongst paramedics. For that reason – and because that reason is so serious – I touch on it briefly here.

The Problem

To find a solution one must understand the causes of PTSD in paramedics. One also must appreciate that paramedics can be very ill with symptoms of PTSD – and have them for decades where they chew away at you and wear you down – but still not reach the level that satisfies the Diagnostic Criteria set down in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM 5) for full blown PTSD.

Causation: Whether it is full blown PTSD or decades of Sub-Syndromal symptoms or undiagnosed PTSD – in paramedics it is usually caused by REPEATED or EXTREME exposure to traumatic/sad events death etc. Without such exposure a Dx of PTSD cannot be made. Thus the solution is to reduce exposure – or if that can't be done – give time out – time away from the sirens for the paramedic's brain to defrag and reboot afresh.

Based on four decades "on the road" – at the coal face – never once applying for rank so all of it has been on the road - until I came down with PTSD (which I now realise I was suffering in a sub-syndromal form for decades) – I believe based on that lived experience we can do much more to fix it.

Presently, a paramedic must be prepared to attend any emergency and be prepared to do so all day every day with no time away from the sirens. This is because we don't properly separate our emergency and non-emergency work. Not every job is life threatening – indeed comparatively few are – so the option is there to split our work into the two groups.

Step one: At present, because the number of ICPs is kept artificially low, those on designated Intensive Care Cars are repeatedly sent to the worst of the worst, day in day out – they have massive and ongoing exposure. It's exciting when you're young but it takes its toll later. All other paramedics (P1s) are also sent to the worst of the worst but because there are more of them, the burden of the worst of the worst is shared between all of them. Not so with ICPs. This does not mean P1s are not exposed to traumatic events. In fact it is terrible to watch a patient die for want of a treatment you should be able to provide them. P1s don't have the extra skills ICPs have and as a consequence – patients die – especially in country NSW.

Step one solution: If all were trained to ICP (or close to it as was supposed to happen before the train all policy was derailed) we would achieve two things. We would not be sending the same ICPs to the worst of the worst every day because all paramedics would be ICP or similar so the burden would be shared across a broader paramedic base. At the same time – the current P1s would be raised to ICP and thus have what they need to keep the patient alive and avoid exposure to their avoidable death.

Step two: Follow Queensland's lead and massively increased the number of paramedics trained as ECPs (preferably adopting QLD nomenclature LARU – Low Acuity Response Unit) and,

like QLD, focussed initially on recruiting "veteran paramedics" to the role will massively reduce the incidence of PTSD, subsyndromal PTSD, undiagnosed PTSD in its paramedics and in turn - suicide.

Step three: In metro and busy regional centres split our service delivery model so that low acuity calls are sent to one controller who despatches a LARU car and high acuity calls sent to another controller who responds a HARU (High Acuity Response Unit). This model still sees the same work volume covered but organises it into low acuity and high acuity and responds resources accordingly. It creates a section of the service where paramedics who first have been trained to ICP (or equivalent) are then trained as LARU Paramedics so they can have time out – time away from the sirens. They may still be confronted with a seriously ill patient when the call has been wrongly triaged or they are close to a serious incident but they are out to the main emergency side of the organisation for a year or two. They are still using their mind and learning on challenging but less stressful calls. Once their brain/min has had time to defrag and reboot afresh – they slip back into the HARU stream and someone else moves to LARU for time out.

Summary:

1. This model sees the same volume of work covered but does it in a more organised way.
2. By training all to ICP, the burden comes with sending a "select few" metro ICPs to the worst of the worst every day is spread across a larger base because everyone is ICP trained.
3. P1s are not exposed to patients dying (especially in country NSW) due to the P1 not having the skills/drugs the patient needs – they are all ICP or equivalent.
4. Splitting the service so low acuity calls are separated from high acuity, the same work volume is covered but it is more organised and LARU provides paramedics with somewhere to go for time out – away from the sirens to defrag and reboot.
5. Targeting veteran paramedics in the first roll out sees those who are already most unwell given the opportunity to have time out. Many will probably stay their till retirement.
6. As they retire younger paramedics train up to LARU (with the goal of all training up) with the aim being that once a new recruit has had say 10 – 15 years in HARU she or he can switch to LARU for a spell and defrag – then switch back to HARU and switch as needed throughout their career thus reducing the trajectory we are all on to PTSD under the current model.

Sincerely

Christopher Cousins