Supplementary Submission No 482b

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

Name: Mr Christopher Cousins

Date Received: 7 February 2022

Dear Committee Members

Having tracked closely the Hearings the Committee has conducted, I hope it is not too late to add a final submission that might assist the Committee in its final deliberations.

Question re Blue Mountains LHD and ambulances

That the Honourable Walt Secord questioned Ms Kay Hyman CE, Blue Mountains Local Health District about the number ambulances available at any given time in her area, makes me question if the Committee realises NSW Ambulance (NSWA) is a separate autonomous arm of NSW Health with its own CE – Dr Morgan (PhD) who seems not to have been called to give sworn evidence or be examined.

Ms Kay Hyman ought not to be expected to know the answer to the question and nor does she have any control over it. Moreover, I doubt her answer as to where someone having a "heart attack" would be taken was right – not if it were a serious "heart attack." These questions ought to have been put to the CE of NSWA Dr Morgan.

The question about where a "heart attack" patient would be taken prompted me to disclose a very serious occurrence with NSWA. So let me tell you a story. A story about equity and show an example of how it can be achieved to give country people a similar health outcome in a heart attack as people in the city.

A heart attack in the bush versus a heart attack in the city

Different models of care to produce better outcomes in the bush

(And following that – how it nearly didn't happen)

I presume the question put to Ms Hyman related to a serious "heart attack." One clinicians would call as a STEMI (ST Elevation Myocardial Infarction). It is called that because the ST segment of the ECG becomes elevated in response to the heart muscle being deprived of blood, and in turn, the oxygen it carries – usually due to a clot in a narrowed part of one of the coronary arteries.

By looking at which leads are raised one can see which part of the heart is involved. Every paramedic NSW can now send a suspect ECG to a cardiologist to confirm the pattern. In metropolitan NSW, patients are taken directly to the closest major hospital with cardiac catheterisation facilities. The pt. is moved straight from the ambulance stretcher to the cath table where the procedure immediately begins in which a wire with a balloon on it is manoeuvred through the blood vessels till it reaches the blocked coronary artery. The balloon is inflated to dilate the narrowed part and break the clot away before a stent is inserted to keep it open. Ms Hyman would have no idea of the nuances involved in this.

In country NSW, cardiac catheterisation facilities can be hours away, so a different approach is needed – and was taken. In country NSW, every paramedic can give powerful drugs to dissolve the clot and others to stop it reforming. Once dissolved the artery reopens, ideally enough to stop the heart attack in its tracks. If not, then it usually opens sufficiently for enough blood to pass through the narrowed area for the heart muscle to survive – and in turn for the patient to survive - until they reach a hospital with a catheterisation facility – either by a long road transport or by air – where they undergo the same balloon procedure as their city counterpart. Sometimes, depending on the location and availability of aircraft, if the heart attack has been resolved by the drugs the paramedics gave, the patient may stay overnight in say Dubbo Hospital and be taken to Orange the next day – the urgency has gone in essence because the patient isn't having a heart attack any more.

The moral of this story is – country people can be offered equitable access to specialised major hospital services and be delivered health outcomes comparable to metropolitan NSW – but only if we tailor the delivery model to conditions in the bush! I doubt we will overcome the tyranny of distance in my lifetime – but we can adapt what we do to overcome a lot of it. But not by taking models which work in Sydney and expecting them to work in the bush.

Because NSW Health has, over the past 40 years, reduced services previously available in country towns in preference to centralising specialist resources at regional hubs, in an emergency, such as discussed here – the paramedics in country NSW must be seen as the facilitators of those good outcomes. It is they who need their scope of practice enhanced so they can do what the local doctor would use to do when they brought a patient to the local hospital in an emergency. Now that option is gone, they need to be able to keep the patient both alive and comfortable if possible, while taking them straight to the regional hub for specialist care – just as they do now with heart attacks – leading to health outcomes similar to those seen in Sydney.

But these outcomes will not be delivered by taking a model of care which works well in Sydney and thinking it will work in the bush. Just like NSWA is doing now, transposing its Sydney based model of strategically placing Intensive Care Ambulances across country NSW expecting it to work as well as it does in metropolitan NSW.

These IC cars will largely be placed at regional hubs – centralising a high level of ambulance care in hubs where like in Sydney, patients are just minutes from a major hospital! Two of these IC cars are to be located at Orange in Central West NSW. It will be fantastic for the 40,000 people living in Orange – who already have a major hospital on their doorstep but what does it do it will do for the 47,000 people living in Blayney, Cowra, Grenfell, Parkes, Forbes, Condobolin, Wellington etc. just to name a few - NOTHING!

To offer better outcomes in the bush ALL country paramedics need to have their scope of practice enhanced to make up for the differences between the city and the bush. Instead, like all of NSW Health, we have centralised city-centric decisions makers taking a Sydney based model of care and trying to make it fit the bush. It doesn't work like that. Unfortunately, we also have egos and tribalism involved. The need to maintain a sense of elitism for many who are in the elite club. They are not expanding ICP to country NSW for the benefit of country

people. They are expanding it because they know they will be forced – hopefully by this committee – to do something. By implementing this strategy, I contend the hope is it will be seen as negating a need to enhance the scope of practice of all country paramedics, so as to maintain the requisite gap to remain elite and special while also keeping the total number of ICPs out there artificially small. I can see no other reason for this.

How country people having heart attacks nearly missed out

When it came time for NSWA to replace the old defibrillators of which Kerry Packer donated many – the Packer Wacker – I was on the committee tasked with drafting the essential criteria for a new defibrillator. Initially it was only to be used by non-Intensive Care Paramedics (non-ICPs).

To cut a long story short, NSWA was pushing us to write criteria which favoured the type of defibrillator now found in most shopping centres. Machines so simple to use that untrained members of the public can take it off the wall and use it successfully. They do not have a screen to display the ECG because they are strictly defibrillators – nothing else.

Even though the Packer Wacker had a basic ECG screen – management on the committee – many of whom were old ICP stalwarts, did not want non-ICPs to have an ECG screen on their machine. Why you ask? Because it broadens the gap between them and those "below them"- so as to maintain their special status.

This is how deeply into the culture of NSWA this division goes. The criteria we settled

upon saw a fantastic machine delivered. It was so good the ICPs wanted it, as did our Aeromedical arm and it was in service for years. An old one I happened to have at home at the time worked when my wife arrested in her sleep. It was so old it should not have worked, but thankfully it did. The local ambulance was busy so the closest had to come from Tanilba Bay – half an hour away. So if it didn't work, she'd now be dead. Yes, I have a personal interest in equity of care for country people.

Had we not taken that stand, and threatened to bring ICAC in country paramedics would be using a defibrillator that does not display the patient's ECG – let alone be capable of capturing a 12 lead ECG. The ability of country paramedics to identify a STEMI would not exist – so they would not be able to give those lifesaving clot busting medications. The ability to do that would be limited to ICPs alone. This is how deeply into the culture of NSWA this division goes. For some it has nothing to do with the patient – and everything to do with their ego and keeping the club small.

Ultimately, country paramedics got an ECG capable defibrillator. When it was replaced it was with one that was 12 lead capable and now, while patients having a heart attack in the country NSW are treated differently to how people are treated in the city – the health outcomes are similar to that achieved in Sydney. We just do it a different way.

This latter point relates particularly to my next point – the failure of NSWA to enhance the scope of practice of its country paramedics as the Legislative Council General Purpose Standing Committee recommended way back in 2008 following its inquiry into the *Management and Operations of the NSW Ambulance Service*.

NSW Ambulance – putting the cart before the horse

Way back in 2008, a committee just like this one recommended the following.

Recommendation 23

"That the Ambulance Service of NSW provide Intensive Care Paramedic training in additional rural locations."

This recommendation was supported by the Government of the day, which told the Committee in it was already addressing the issue, and that provisions a *"for better geographic spread of Intensive Care Paramedics is part of the Ambulance Service's Clinical Profile Plan;"* [1] and that the plan supported the *"better distribution of Intensive Care Paramedics based on community need."* (My emphasis).

However, that training never eventuated. Nevertheless, NSWA has just spent **$11.72 million** on brand new **intensive care ambulances** to be parked at **31 ambulance stations** in country NSW – **with no one to drive them -** because the training was never done.

Don't believe me? Have a look at **TAB A** - the announcement by Ms Clare Beech, Executive Director, Clinical Systems, NSWA in relation to the roll out of new intensive care ambulances and an additional $34 million to train just 246 paramedics to ICP and put 203 of them at 31 stations across country NSW. What about the people served by the remaining 140 or so stations located in what can be reasonably described a country NSW. That $46,000,000,000 would surely be far better spent upskilling all paramedics in country NSW – not just a handful.

Now that you have had a look at TAB A, when you're next up here on holiday, pop your head into Nelson Bay ambulance station – now with the assistance of the 2008 Committee is now located centrally located at Salamander Bay. You will see, parked in the plant room, a brand new fully equipped Intensive Care Ambulance worth $160,000. There's picture of it below. But Nelson Bay has 1 ICP attached to the station. So out of the 14 paramedics it takes to cover the roster at Nelson Bay, just one is an ICP, so there is just one to drive it. This means it will sit idle for 23,712 shift hours P/A. See **TAB B** for how this calculation is arrived at.

[1] NSW Government Response to the GPSC2 Inquiry into the Management and Operations of the NSW Ambulance Service. P11.

New IC car at Nelson Bay to sit idle for 23,712 shift hours pa. (See **Tab B** for calculations).

If this does not represent a serious and substantial waste of public money, I don't know what would – particularly if it is repeated at other locations. A very quick – ten minute review of the plan set out at TAB A found nine stations with either zero or one ICP to drive their new IC car or on stations given two – just two ICPs – one to drive each.

What was found in that very quick review is depicted in the table below. One can only wonder what a thorough review would reveal.

Station	**# of IC cars per plan**	**Current # ICPs at station**
Raymond Terrace	One	Zero
Beresfield	One	Zero
Nelson Bay	One	One
Cessnock	One	One
Kempsey	One	One
Birmingham Gardens	One	One
Inverell	One	Two
Oak Flat	Two	Two
Queanbeyan	Two	Two

It is difficult to see value for money in this plan. Surely the $160 k per car could have been better spent enhancing the scope of practice of all country paramedics so they can equitably deliver a higher level care to all people in country NSW and at least in part, make up for the tyranny of distance and deliver better health outcomes across the board for country people.

Equitable access to high level care

Looking at it in the context of where I have worked for decades now. For the best part of a couple of decades, nearly all of the paramedics attached to Nelson Bay were Advanced Life Support Paramedics. Two others were Sydney trained ICPs who moved to Nelson Bay because like for the rest of us – it's a great place to live. In time, as noted in the Governments response to:

Recommendation 24

That the Ambulance Service of NSW reinstate training to Advanced Life Support level for paramedics in rural and remote areas. Rural officers should be given priority of training.

All ALS were supposed to be given the opportunity to upgrade to ICP. Four ALS upgraded to ICP. Some chose not to. One (guess who) was never allowed to. Trouble makers don't get to advance in NSWA.

As older ALS and ICPs retired or got put out due to PTSD, they were replaced by P1 – base trained paramedics. As a consequence there is now just one ICP attached to the station to work the roster and one ALS. The ALS is me – but the recent report by the independent medical expert the insurer sent me to, came back saying I have chronic PTSD so I am never to work the road again – and another one bites the dust. So Nelson Bay has a shiny new Intensive Care Ambulance parked in the garage but only one ICP to drive it.

Even if it did have enough ICPs to crew it, where is the equity in giving the people of Nelson Bay intensive care paramedics but not the people of Tanilba Bay? It's a half hour run from Nelson Bay to Tanilba Bay so what use is it to them.

In fact, Tanilba Bay has two ICPs and two ALS – and ALS and ICP were very close to each other in the level of interventions they could provide (until NSWA just upskilled all ICP with new equipment and procedures under guise of being COVID related to attract the

funding. Maybe the new car should have gone to Tanilba – put the two ALS through the ICP COVID upgrade and they will be artificially different again.

Community engagement

It is noted that unions have been consulted in the plan set out in TAB A – but the unions did not consult with their members in relation to what was agreed. The real question however is - what community consultation occurred, and how did NSWA make what most reasonable people would see as being akin to *Sophie's Choice* – who will live and who will die. That's how you can sum this plan up. Some people are worth more than others.

At **Tab A** you will see Ms Beech says the choice of location for ICPs was not based on community need, but on some undefined *"statewide capability assessment"* and some work volume and acuity formula.

Where a station was allocated two IC cars it was because it had sufficient workload to *"support the potential future training of ICPs."* At stations allocated one car – the decision was based on them having *"an acceptable case-mix to maintain and sustain currency and recency of practice in a quality and safe manner…"* Therefore, the choice of which stations get IC cars was based on training and "skill maintenance" needs – not community needs as was promised by the Government of the day in its reply to the 2008 report. Moreover, the formulas and methodology by which NSWA reached these conclusions has not been made available so no one can analyse it to establish its validity. What constitutes *"an acceptable case-mix"* What is the frequency and timeframes arounds maintaining and sustaining *"currency and recency of practice"* and what constitutes *"a quality and safe manner…"*

Transparency

In what is ultimately a Sophie's Choice, the community should have access to the data NSWA relied upon in choosing which towns were to get ICP and which were to be left to die. Without access to that data and explanation of the motherhood statements relied upon it is

impossible to have an informed opinion on the validity of the reasons or rationale relied upon to make this Sophie's Choice. That I contend is unacceptable. There must be full disclosure on why some will get ICP while others will be left to die. Indeed, there should be full disclosure and I contend the Committee should fully examine why ALS training for country paramedics was abandoned and do its utmost to see it reinstated – but with long overdue enhancements so all country people are afforded a high level of clinical care.

Recommendation 24

That the Ambulance Service of NSW reinstate training to Advanced Life Support level for paramedics in rural and remote areas. Rural officers should be given priority of training.

The Government of the day did not support the recommendation to reinstate ALS training, presumably based on advice from NSWA it saying it had been *superseded by developments to core paramedic training…* and *"Current Advanced Life Support **officers** are being offered the opportunity to upgrade to Intensive Care Paramedics…"* Note the terminology used. In one sentence they refer to everyone as paramedics but the old stalwart ICPs back then could not refer to us as Advanced Life Support Paramedics!) That was the hatred those old stalwart ICPs had for ALS and that is the reason the aim to train all was abandoned – to keep the gap between them and those below them as wide as possible.

Just look at the COVID upgrade for ICPs. P1s and ALS should have been included in much of it. Instead, they are left doing the same thing – but doing it a much harder old fashion way. Moreover, the core developments in paramedic training (P1) did not bring them anywhere near to ALS.

Equity and the Medicare Principles

The States must have arrangements in place to ensure all eligible persons have equitable access to hospital services regardless of geographic location. [2] But the poor sod has to still be alive by the time they reach that hospital, if we are to say they had equitable access to those services.

Over the past 40 years, NSW Health has slowly, withdrawn services from smaller country towns and used those saving to concentrate or centralise sophisticated specialist medical

[2] Clause 8c - National Health Reform Agreement – Addendum 2020-25

services in regional hubs. While that has been at the expense of smaller towns (and we've probably gone too far) it was probably the right thing to do. However, as with everything, those with carriage of it did it in a vacuum.

They failed to improve ambulance services and training of country paramedics at those smaller towns and equip them with the tools and enhanced scope of practice to make up for the inability to get the patient stabilised or resuscitated – using additional drugs and procedures at the local hospital. Part of the solution for that was the aim to train all country paramedics to Advanced Life Support – but that maladministration saw that derailed – because it threatened the elite status of ICP.

What is needed to remedy the terrible wrong NSWA did to country people so long ago

Until recently I was studying law by distance learning through UNE. In an effort to find a role away from the sirens to manage my PTSD, I enrolled in a Grad Cert Extended Care Paramedicine – again online (with a practicum component) – but that was a waste of $6k if I am not to be allowed to work as a paramedic again.

An online conversion from P1 to ALS is equally achievable. If the will is there, all country paramedics could be brought up to Advanced Life Support in stages – one component at a time and within a couple of years all country paramedics could be ALS and country people, even in small towns undeserving of specialist ICP's will have equitable access to the highest level of care they could reasonably expect in a country like Australia. However, the Advanced Life Support scope of practice should be expanded to include some of the ICP COVID upgrades as follows:

1. **EZIO access.** ALS already insert intraosseous needles in moribund children but they do it manually by hand, using a difficult to master twisting motion. The COVID upgrade saw ICP equipped with a drill to do the same thing faster, better and more safely. P1's upgrading to ALS should have the same.

2. **External pacing** – ALS can already give atropine and adrenaline for bradycardia. Since the machines we use can also do external pacing in bradycardia so when adrenaline and atropine fail ALS should also be able to pace the patient to keep them alive until they reach a larger hospital. Paced patients usually need to be sedated because being paced is not comfortable. Sedation is already in the ALS scope of practice so there is nothing to prevent pacing being included in their scope..
3. **CPAP** – In pulmonary oedema the tiny air sack into which air must enter so when we breathe in so oxygen can pass from the air into the capillaries through the thin membrane which makes up the walls of the tiny sacks become filled with fluid leaking from the capillaries, stopping air from reaching that thin membrane. With CPAP the patient breathes in and out against a continuous positive pressure. This not only makes it easier to breath in – the pressure has the effect of pushing the fluid building up in the small air sacks back into the blood stream where it belongs and oxygen exchange can then take place. ALS already treat this condition with drugs just like ICPs P1's don't. But both P1s and ALS must rely on a difficult to handle and difficult to coordinate procedure in which they manually hold a resuscitation mask and bag over the patient's mouth and nose and try to squeeze the bag each time the patient breathes in. It takes enormous work to get a panicking patient to work with you trying to do this. While profoundly difficult – it works. CPAP does the same thing but in a much easier and much more patient friendly manner – yet these specialist ICPs are given the easy way to do it leaving the rest of us to battle on doing it the hard way – why? It should be included for P1's now and certainly in their ALS upgrade.

4. **IV Amiodarone in Ventricular Fibrillation** – ICPs use amiodarone in patients in ventricular fibrillation and tachycardia. ALS and P1s do not; however they do shock VF and VT based on the diagnosis they make looking at the ECG screen. If they can be trusted to identify and shock those rhythms, why not authorise them to give amiodarone between shocks. Studies have shown the benefit of IV amiodarone – improved survival neurologically intact - is greatest if given within 20 minutes of the patient arresting. [3] The only way country people can get the benefit and hopefully achieve a better health outcome from a VF arrest is to include amiodarone in the P1/ALS scope of practice.

How can a plan be the right plan for country NSW when it will see someone in cardiac arrest at Nelson Bay get what they need to survive from an ICP (even if we only have one) while if the same person arrested while visiting a friend at Tanilba Bay – they won't get what they need.

Only by training all country paramedics to Advanced Life Support and adding the above, can the State fulfil its obligations to ensure all eligible persons have equitable access to hospital services – and more than that – it just offers fairness and equity when it counts – when someone's life is in the balance.

If NSW refuses to train all P1's to the enhanced ASL level it should instead, via distance learning train all P1's in:

---

[3] Lee, D.K., Kim, Y.J., Kim, G. et al. Impact of early intravenous amiodarone administration on neurological outcome in refractory ventricular fibrillation: retrospective analysis of prospectively collected prehospital data. Scand J Trauma Resusc Emerg Med 27, 109 (2019). https://doi.org/10.1186/s13049-019-0688-1

Wissa, J. , Schultz, B. , Wilson, D. , Rashford, S. , Bosley, E. & Doan, T. (2021). Time to amiodarone administration and survival outcomes in refractory ventricular fibrillation. Emergency Medicine Australasia, 33 (6), 1088-1094. doi: 10.1111/1742-6723.13841.

Soar, J. (2018). Antiarrhythmic drug therapy during cardiopulmonary resuscitation: should we use it?. Current Opinion in Critical Care, 24 (3), 138-142. doi: 10.1097/MCC.0000000000000498.

- P1 paramedics must be trained and authorised to insert an intragastric tube thorough the LMA port down the oesophagus into the stomach and suction the liquid components of the stomach to prevent it contaminating the trachea and lungs.
- P1 paramedics must be trained and authorised to sedate patients for painful procedures such as straightening badly broken and deformed limbs similar to that which non-degree ALS paramedics have performed successful for decades.
- Every ambulance in NSW must be equipped with a mechanical chest compression device, so that a crew of two paramedics in country NSW can immediately be turned into a crew of three by releasing one of the two paramedics from the chest.
- P1 paramedics in country areas must be trained and authorised to give amiodarone IV or IO in VF or pulseless VT where it has failed to respond to three DC shocks. They already give electric shocks to the patient's heart based on what they see on the ECG reading – so how is giving amiodarone different?
- P1 paramedics in country areas must be trained and authorised to give amiodarone IV in VT where the relevant machine interprets the 12 lead ECG as indicating the pt. is in VT at a rate where the patient has a pulse with a rate over 150bpm and the pt. is hypotensive or their perfusion is compromised.
- P1 paramedics in country areas must be trained and authorised to administer atropine where a patient's heart rate is below 50 BPM and their BP is below "x" and or perfusion status is compromised.
- P1 paramedics in country areas must be trained and authorised to either administer adrenaline IV or IO where atropine has failed, or in the alternative – initiate external transcutaneous pacing and sedation as required to make it comfortable for the patient.
- P1 paramedics must be trained and authorised to utilise intraosseous vascular access via the EzIo device.
- P1 paramedics must be trained and authorised to administer Frusemide to patient in severe left ventricular failure (pulmonary oedema).
- P1 paramedics must be trained and authorised to offer a patient in severe left ventricular failure (severe LVF or pulmonary oedema) continuous positive airway pressure via the simple device recently introduced for ICPs. This device means it is simple for the supposedly higher trained ICPs to manage severe LVF while lesser trained non-ICPs are left trying to wrestle with the patient, forcing a mask over their face – which subjectively they feel is suffocating them - to which is attached a football like bag which the paramedic has to squeeze in time with their attempts to take a breath in. Executing that takes a lot of experience. I can't count the number of times I have given a patient frusemide and other drugs to help stop them drowning in the

fluid in their own lungs. What I can say is that, we don't get patient in severe LVF very often anymore.

- Trying to synchronise the squeezes of the bag with the patient's attempts to inhale or – breathe in is incredibly hard. Try holding your breath for three minutes. When you finally have no choice but to breathe – then think of that moment. For you, the ability to take a new breath releases all of any anxiety you may have built up.
- Now think of my patient who cannot take the next breath. They don't even have the strength to fully exhale before their body demands more oxygen to survive and in turn they are forced to inhale – even before they have finished exhaling.
- Yet, supposedly higher trained and more expert ICPs are given the easy option of CPAP – while the rest of us are left struggling to gdt the pts confidence so we might breathe from them and synchronise their breaths in with us squeezing the bag trying to inflate their lungs. It's fucking hard to sync that so well that you get the patient's confidence – so why not just give P1s the same easy option given to ICPs – oh that's right – I forgot for s moment – it is not the patient or the community of NSW that is of importance. The priority is keeping ICPs special.
- P1 paramedics in country areas must be trained and authorised to reduce simple dislocations such as the patella, digits and anterior shoulder dislocations.
- P1 paramedics must be trained and authorised to initiate antibiotic therapy for community acquired pneumonia or urinary tract infections in the elderly provided they can arrange review by the patient's GP practice within 48 hours.
- P1 paramedics in country areas must be trained and equipped to suture simple lacerations.
- P1 paramedics in country areas must be trained and equipped to insert or replace indwelling urinary catheters and troubleshoot catheters already in-situ.
- Given ambulances in metro NSW now carry mechanical chest compression devices which can perform "CPR" better than a paramedic, both while being extricated from a building and while in transit to a nearby hospital with cardiac catheterization facilities where the culprit coronary artery causing the heart to stop can be unblocked – and ambulances in country NSW either do not have mechanical CPR devices – or they are too far from such facilities; the Committee should consider supporting a trial in which those who are too far from such a facility be given the chance to have the culprit artery opened via thrombolytic therapy.

Christopher Cousins