**Submission No 28**

# INQUIRY INTO IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

**Organisation:** Australasian College of Paramedicine

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13 September 2022

Parliament of New South Wales
Legislative Council
Portfolio Committee 2 - Health
By Email: PortfolioCommittee2@parliament.nsw.gov.au

Dear Portfolio Committee No.2 – Health,

**Submission – Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales**

The Australasian College of Paramedicine (the College) welcomes the opportunity to make submissions to the Inquiry into ambulance ramping and access block, and to contribute to the impact this has on the health system, particularly the operation of hospital emergency departments in New South Wales (NSW).

The College is the peak professional body representing and supporting over 10,000 paramedics and student paramedics across Australia and New Zealand, including NSW-based members. The College champions the role of paramedics in emergency, out-of-hospital primary, and palliative care, and we are committed to enhancing patient-centred care. The College is future-focused and brings together paramedics from across Australasia to represent, advocate, promote and celebrate the achievements of this critical registered health profession and drive a connected, multidisciplinary approach to high-quality health care in all communities.

The intersection between health care services in this setting, ambulance services and hospitals, is complex. Individual patient needs and the journeys required to meet them are unique to each individual, but their experiences and poor health care outcomes are not. The negative consequences of access block, ED overcrowding and ambulance ramping on patient outcomes and staff adherence to guideline-recommended treatment, are well established[1].

The College advocates for a whole health approach, across traditional jurisdictional and government boundaries, in implementing innovative, patient-centred solutions based on evidence.

***a) The causes of ambulance ramping, access block and emergency department delays:***

Ambulance Ramping

Ambulance ramping, access block and emergency department delays are each uniquely different. They may be isolated to just one phenomenon, but often they are interrelated and always impact the patient negatively when prolonged. Ambulance ramping, also known as 'patient off stretcher time delay' or 'offload delay', refers to the time taken for patients unable to be transferred from the ambulance stretcher to the emergency department promptly.

The Australian Medical Association (AMA) reports that states and territories are falling short of their performance targets, and transfer times are increasing yearly.[2]

[1] Richardson B.D, Access block in Australia emergency departments 2017-2020. Available from https://doi.org/10.1111/1742-6723.13738 https://doi.org/10.1111/1742-6723.13738
[2] AMA Ambulance Ramping Report Card. https://www.ama.com.au/articles/ama-ambulance-ramping-report-card. Accessed 09/05/22.

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Multi-factorial causes include:

- Emergency Departments at capacity (all beds occupied)
- Multiple ambulances arriving at the Emergency Department simultaneously
- Mass casualty emergency event
- Lack of incentive to transfer patients off ambulance stretchers
- Centralisation of Health care facilities and gradual reduction in the capacity of rural hospitals, necessitating ambulance transfers to more extensive more capable health facilities
- All Ambulance admissions from outlying hospitals occur through the Emergency Department.

Access block

The diagram below highlights system factors that contribute to access block.

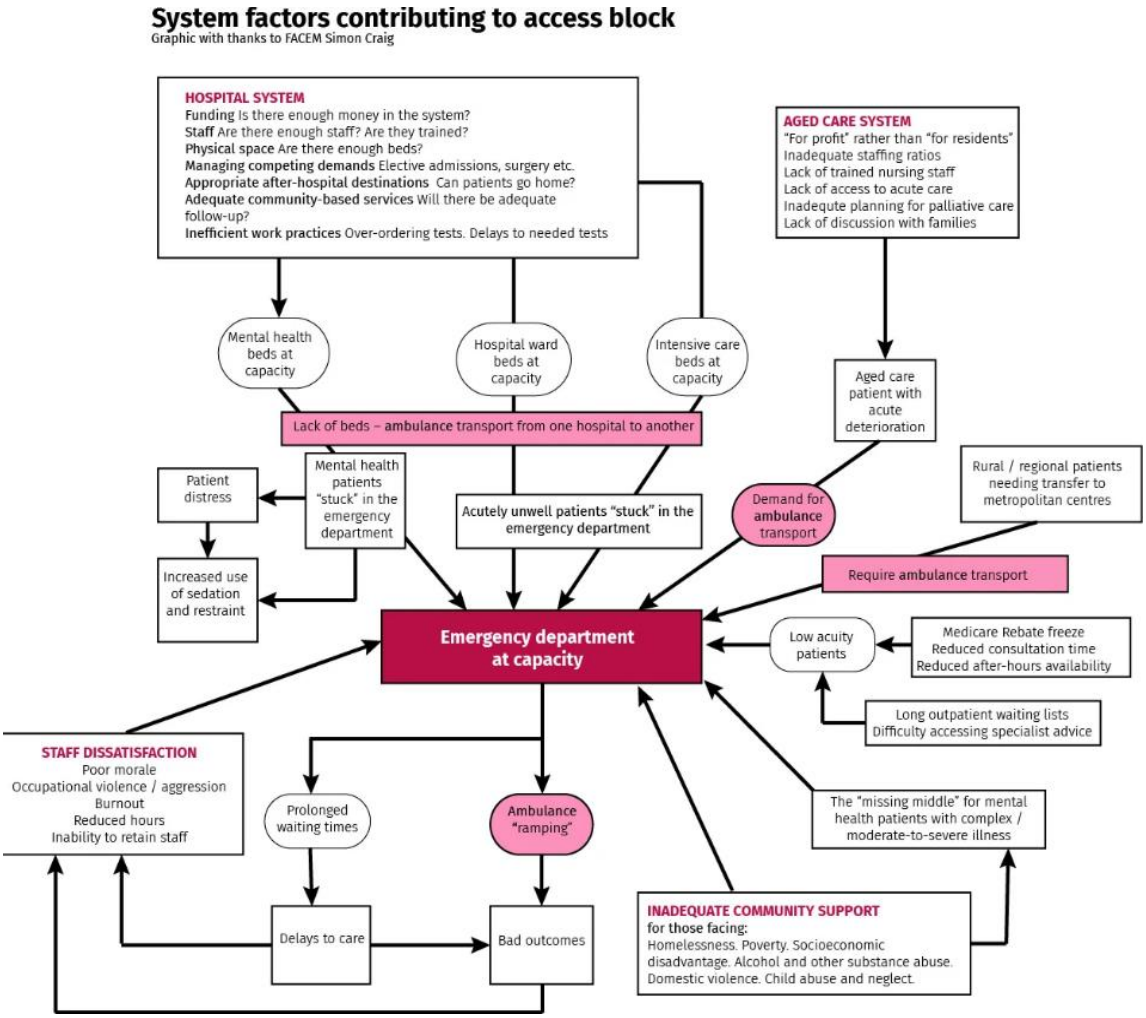


Diagram Credit to FACEM Simon Craig [ Simon-Craig-diagram-re-draw-2.jpg (1254×1080) (acem.org.au) ]

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Access block refers to the situation where patients in the emergency department (ED) requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable time frame.[3,4] In Sep 2020, an average of 67 per cent of current patients waiting for admission were suffering access blocks across 93 Australian emergency departments.[5]

Multi-factorial causes include:

- Hospital Occupancy[6]
- Delays in discharge the inefficient flow in the discharge process.
- Insufficient bed capacity[7]
- Hospitals are impacted by the after-effects of the National Emergency Access Target (NEAT) initiative (NEAT stipulates that a pre-determined proportion of patients should be admitted, discharged, or transferred from Australian EDs within 4 hours of presentation), which resulted in a widespread and disproportionate increase in hospital admissions[8]
- Elective Surgery
- People who present to EDs with mental health issues are at greater risk of experiencing access blocks.[9]

The Australian Institution of Health and Welfare (AIHW) data indicates that in 2018-19, more than 522,500 ED patients suffered access blocks.[10] Between 2017-19, daily presentations rose by 11.4 per cent, and the number of patients who experienced access block increased by 46.1 per cent. Hospital admissions decreased to their lowest during the COVID-19 transmission peak but rose to pre-pandemic numbers by September 2020.[11]
In September 2020, the number of patients experiencing access block increased to 67 per cent.[12] The cost associated with inappropriate ED bed occupancy represents a significant cost to individual emergency departments and, consequently, to the overall healthcare system. According to Australasian College for Emergency Medicine (ACEM) internal analysis, this cost Australia's health system AUD$583 million (range of $222-833 million).[13]

Emergency Department Delays

Emergency Department delays refer to the patients presenting to the emergency department unable to get treatment promptly. There are recommended treatment target times related to the relative acuity of the nature

[3] Fatovich DM, Nagree Y, Sprivulis P. Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia. Emerg Med J 2005;22:351–354
[4] Bein KJBR, Saartje, Ní Bhraonáin, Sinéad, Seimon, Radhika V, Dinh, Michael M. Does volume or occupancy influence emergency access block? A multivariate time series analysis from a single emergency department in Sydney, Australia during the COVID-19 pandemic. Emergency medicine Australasia. 2021;33(2):343-8.
[5] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.
[6] Bein KJBR, Saartje, Ní Bhraonáin, Sinéad, Seimon, Radhika V, Dinh, Michael M. Does volume or occupancy influence emergency access block? A multivariate time series analysis from a single emergency department in Sydney, Australia during the COVID-19 pandemic. Emergency medicine Australasia. 2021;33(2):343-8.
[7] INH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.
[8] Silk K. The National Emergency Access Target: aiming for the target but what about the goal?: deeble institute; 2016.
[9] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.
[10] AIWH, Emergency department care, Emergency department care - Australian Institute of Health and Welfare (aihw.gov.au)
[11] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.
[12] *IBID*
[13] https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block

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of the patient's presentation, which is also associated with a funding model disincentive; urging staff to 'people push' than to proceed through the continuity of care.[14,15]

Multifactorial causes include:

- Reduction in primary health care services and limited extended hours available from General Practitioner services in the community, especially in regional areas[16]
- Increases in ED presentations in Australia are driven by two broad patient groups: sick older adults and young adults with acute mental health problems[17,18]
- Difficulty staffing services; unbalanced physical and functional capacity for patients and ED staff.[19]

***b) Effects that ambulance ramping and access block have on the ability and capacity of emergency departments to perform their function;***

Ramping challenges ED systems of care and scopes of practice[20] and are represented in health services when they are overwhelmed, where "patients receive sub-optimal care, including delays in assessment and treatment."[21] Staff have an increased risk of exposure to error and pressure to meet four-hour turnover, which has led to symptom treatment rather than core issue treatment. Longer offload times are associated with a greater risk of death and ambulance re-attendance within 30 days.[22]

Ambulance offload delays ("ramping") have caused substantial concern during the past decade in Australia. In 2015-19, the median offload time increased from 21 minutes to 24 minutes, highlighting that longer offload times exceeding 17 minutes increased the risk of death and reattendance[23].

Startlingly, access block and ED overcrowding contributed to a 20 per cent to 30 per cent excess mortality rate every year, approximately 80 deaths per million population.[24] These numbers were calculated in 2009 to demonstrate the ability of the system to meet demand at the time. In the wake of COVID-19, our health systems are overwhelmed to utter distress.

In September 2020, more than two-thirds of patients waiting for hospital admission were access blocked. These patients accounted for 21 per cent of the entire ED staff workload, an increased workload on ED staff.[25]

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[14] Scott IA. Public hospital bed crisis: too few or too misused? Australian Health Review 2009;34(3):317-24.v
[15] Jones PG, Werf Bvd. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emergency Medicine Australasia. 2020;33(4):655-64.
[16] Crawford J, Cooper S, Cant R, DeSouza R. The impact of walk-in centres and GP co-operatives on emergency department presentations: A systematic review of the literature. International emergency nursing. 2017;34:p.36-42.
[17] DINH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.
[18] W. Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L, Bellolio F. Emergency department crowding: A systematic review of causes, consequences and solutions. PloS one. 2018;13(8):p.e0203316-e.

[19] O'Connor K, Golding M. Assessment of the availability and utility of the paramedic record in the emergency department. Emergency medicine Australasia. 2021;33(3):485-90.
[20] Phillips WJ, Cocks BF, Manthey C. Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, & Policy. 2022; Publish ahead of print.
[21] DINH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.
[22] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022.
[23] *IBID*
[24] Fatovich DM, Hughes G, McCarthy SM. Access block: it's all about available beds. The Medical Journal of Australia. 2009;190(7):362-3.
[25] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.

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***c) Impact that access to GPs and primary health care services has on emergency department presentations and delays***

Access to after-hours primary health care contributes to patients visiting ED for non-urgent conditions.

The increased low acuity ED presentations (GP-type presentation), an aging population, and population growth contribute to the overall increase in ED presentations.[26]
The lack of understanding of what accurate GP-type ED presentation looks like – different understandings identified in the literature. This difference is more complicated for rural and remote areas with GP shortages.[27]

- Patients need consistent, ongoing care from a GP (continuity of care), but GPs are not appropriately funded, making ongoing care harder. "GPs are set up to fail by the system that is fragmented, rigid, and unsupportive."[28]
- GP services are predicted to outpace supply.[29]

***d) Impact that availability and access to aged care and disability services have on emergency department presentations and delays***

AIWH analysis indicates that the higher rate of use of hospital emergency departments for non-hospital services in outer regional and remote areas partly occurs within a broader context of the supply of health services in terms of type, volume, and geographical distribution. Data from the Medical Workforce Survey indicates that the supply of employed medical practitioners, especially non-GPs, decreases with remoteness, with most tending to be concentrated in urban areas.[30]

People with chronic disease or aging generally have more complex problems that require more investigation and take much longer in the emergency department. Hospital occupancy is the most significant contributor to access block. It is attributable to the lack of aged care and disability services beds in the community, where those who no longer require acute care can safely reside.[31]

***e) How ambulance ramping and access block impacts patients, paramedics, emergency department and other hospital staff***

Impacts on paramedics:

Ambulance ramping and access blocks impact paramedics in several ways. Paramedics exposed to ramping identify many negative experiences (verbal abuse, physical abuse, compromised patient care, and patient fatality).[32] These negative experiences contribute to high depression, anxiety, stress, and posttraumatic stress disorder symptoms.[33] Ambulance response times in the community have deteriorated whilst ambulances are

[26] Yang B, Messom R. Association between potential primary care emergency service and general practitioner care utilisation in New South Wales. Emergency medicine Australasia. 2021;33(1):52-7.
[27] *IBID*
[28] Breadon P. General practices are struggling. Here are 5 lessons from overseas to reform the funding system Online: The Conversation; 2022 [Available from: https://theconversation-com.cdn.ampproject.org/c/s/theconversation.com/amp/general-practices-are-struggling-here-are-5-lessons-from-overseas-to-reform-the-funding-system-188902.
[29] Deloitte. General Practitioner workforce report 2022: Prepared for Cornerstone Health Pty Ltd May 2022. Online. 2022.
[30] Access to health services by Australians with disability, Content - Australian Institute of Health and Welfare (aihw.gov.au)
[31] Scott IA. Public hospital bed crisis: too few or too misused? Australian Health Review 2009;34(3):317-24.
32 Sullivan C, Staib A, Griffin B, Bell APA, Scott API, Hospital PA, et al. The Four Hour Rule: The National Emergency Access Target in Australia Online: Queensland Government; 2016.
[33] Phillips, W. J., Cocks, B. F., & Manthey, C. (2022). Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. https://doi.org/10.1037/tra0001241

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ramped at hospitals. This leads to worse health outcomes for those in the community with life-threatening emergencies waiting for an ambulance response, with more severe cases spending more time ramped before offload.[34]

Impacts on ED Staff:

Ambulance ramping and access blocks ramping lead to workload issues such as missed meal breaks, overtime, independent feelings of frustration and responsibility for the potential harm to patients waiting for care, which adds to the strained relationship with paramedics.[35] In 2019, access block and ED overcrowding were identified as the top workload stressors for ED staff.[36]

Impacts on patients:

Ambulance ramping and access block impact patients detrimentally. Patients are likely to face delays in assessment and treatment, increased risk of exposure to error, increased length of stay in the hospital, worse health outcomes and increased inpatient mortality.[37]

Recent research from New Zealand has shown that new patients presenting to an ED have a 10 per cent greater chance of dying within seven days of admission when experiencing delays in admission, while more than 10 per cent of current patients waiting for admission in that ED are suffering access blocks.[38] Additionally, up to 3 per cent of hospital bed days result from waiting for imaging, consults and other waits that could be reduced.[39]

***f) Effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays;***

The current NSW Health measures are ineffective in addressing ambulance ramping, access block and emergency department delays. There have been increased reports of ambulance ramping in the last two years, with people needing to be driven to the ED when no ambulances were available and people dying while waiting for one.[40]

Action to expand hospital services in the community has not received the support and funding to be truly successful. This is evidenced by the severity of the ramifications present now. To lessen the burden of the identified challenges, NSW Health and NSW Ambulance Service have implemented Secondary Triage Services, which should be expanded further. This would successfully manage to divert more patients away from ambulances and EDs.

***g) Drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider addressing the impact of ambulance ramping, access block and emergency department***

[34] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022.
[35] Phillips WJ, Cocks BF, Manthey C. Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, & Policy. 2022;Publish ahead of print.
[36] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.

[37] Access block, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block
[38] Werf. B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand
[39] Cameron PA, O'Reilly GM, Mitra B, Mitchell RD. Preparing for reopening: An emergency care perspective. Emergency medicine Australasia. 2021;33(6):1124-7.
[40] AMA report card

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The AIHW data from 2020-21 showed a total of 3,068,572 ED presentations in New South Wales, of which 2,039,135 ED consumers were not admitted or referred.[41] Whilst the College acknowledges that many patients require assessment, diagnostics, and treatment in EDs, providing care to even a subset of these patients in the community through Urgent Care Centres, GPs, and multidisciplinary teams would deliver considerable savings to the NSW health system.

The following alternative service delivery models highlighted below would meet the community's needs and address ramping, access block and emergency department delays:

- Community profiling program was undertaken across rural, regional and remote New South Wales to identify the paramedic needs of communities.
- Ensure the equitable distribution of paramedics at all levels, including Extended Care and Intensive Care Paramedics and update ambulance deployment modelling to reflect present-day demand, ensuring that ambulances are deployed as rostered.
- Explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor.

**Recommendation 1:**
Expanding Community Paramedicine (CP) / Extended Care Paramedic (ECP) to proactively combat the increased presentations of the aging population in the ED and transition back into the community.

The aging population consumes substantial hospital resources due to the lack of appropriate clinical care available in nursing homes and communities, further exacerbating the access block issue.[42] To address this, there need to be improvements to existing exit procedures; timely home care assessments, simplified and achievable disclosure agreements between the private and public services, and proactive interventions to identify potential at-risk patients.[43,44]

Aged care facilities must provide holistic care to deliver palliative and end-of-life care in the home or facility. With community paramedics as part of multidisciplinary teams with doctors and nurses, Australia's aging population can be treated and managed comfortably in the home/aged care facility, where the hospital could be a last resort or reserved for acute injuries before being released back to aged care. In 2020-21, inefficient hospital exit procedures cost approximately $197 million.[45]

Many profiling tools used to identify at-risk older Australians have standard features such as age, co-morbid conditions, and hospital presentation history.[46] Given the recent advancements in tracing technology and services in the past two years, there is an opportunity to refine existing tools to better track and intervene with these individuals. Significant reductions could be achieved by having in-the-home care that avoids ambulance transfers, ED presentations, and other risks to the patient, which could be reduced by having a single health care provider attend to the patient on-site.[47] There are currently no effective models to do this well, and the current model is unsuitable. Within the first 90 days of aged care assessment, one in five older Australians had

[41] Australian Institution of Health and Welfare. Available at https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care, 09/09/2022.
[42] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.
[43] *IBID*
[44] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.

[45] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.
[46] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.
[47] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.

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an unplanned hospitalisation or ED presentation.[48] The value of having a specially trained health care provider/professional to tend to these home cases and facilities would reduce the financial strain on hospitals to triage, assess, consult, treat, and refer/discharge patients presenting with non-urgent needs.

Providing patients with more options for multidisciplinary home care would also steer them away from ED environments, which pose more significant substantial risks for older people, especially patients from residential care facilities.[49] Risks include deconditioning, delirium, hospital-acquired infections, pressure injuries and falls.[50] It is suggested that 13-40 per cent of all transfers from home care facilities to the ED could be avoidable by providing clinical care within these facilities and/or models.[51]

**Recommendation 2:**
Implementing Community Paramedicine (CP) across urgent, primary, and aged care.

A comprehensive implementation of community paramedics across urgent, primary, and aged care would support quality patient-centred care through organised health care networks.

The College proposes the wider introduction of community paramedics, as defined in rural NSW and other jurisdictions, as a contemporary paramedicine model of care where paramedics apply their training and skills in non-traditional community-based environments outside the usual emergency response/transport model.[52] Paramedics are committed to enhancing the patient and carer experience and work with diverse communities to design services appropriate for different community needs. Since the introduction of paramedic registration, paramedics are increasingly working across various health care settings, not just within jurisdictional ambulance services. Paramedics are used in various health care models internationally and across Australia. These models of care utilise the highly qualified paramedic workforce uniquely placed to support existing health infrastructure to deliver responsive, flexible, high-quality, and affordable primary and community health care services.

Paramedics are educated and experienced in providing emergency care, as well as low acuity health care to people in a variety of different settings. Paramedics attend a wide variety of patient presentations, ranging from critical, and traumatic injury to chronic, complex medical syndromes in aged care facilities, mental health illness, substance use disorders, and palliative and end-of-life care.

Community Paramedics should be utilised within the following services:

- Urgent Care Clinics (UCC)
- Aged care centres, NDIS and home care service providers
- Hospital in the Home programs
- With NSW Ambulance to treat and refer low/mid acuity patients in the community away from ED
- In rural and country areas to be utilised across the health service, providing the emergency response ambulance service, supporting the volunteer ambulance officers, and working with the local GPs, health clinics, and country hospitals.
- With GP in health clinics to provide clinic and in-home health care as part of multidisciplinary teams.
- As part of palliative care teams.

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[48] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.
[49] Gurung A, Rome M, Clark S, Hocking J, Dhollande S, Broadbent M. The enigma: Decision-making to transfer residents to the emergency department; communication and care delivery between emergency department staff and residential aged care facilities' nurses. Australasian Journal on Ageing. 2022;00:1-8.
[50] *IBID*
[51] *IBID*
[52] International Roundtable on Community Paramedicine. 2020. Available from international roundtable on community paramedicine > About Us (ircp.info)

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The introduction of community paramedics in these areas would reduce hospital ED presentations / re-presentation, and assist hospital outflow by providing in-home post-discharge care allowing more patients to be discharged knowing they will be cared for appropriately.

The best health outcomes are achieved when health services provide the most appropriate patient care at every point in their journey. The following strategies should be considered when using Community Paramedicine for non-emergency situations in response to receipt of Triple Zero (000) calls to facilitate diversion to low acuity pathways will address ambulance ramping, access block and emergency department delays:

- Develop new protocols and capabilities that enable NSW ambulance care contact centre to safely divert non-emergency callers to care pathways that are more suited to their care needs
- Use community paramedics to provide secondary triage and to deliver non-emergency responses for patients
- Grow community paramedicine scope of practice and operating models.[53]

Community paramedics also have the capacity to support GP services, rural health clinics, urgent care centres and minor injury units. These health service groups would see paramedics work more comprehensively as part of an integrated multidisciplinary team.

**Recommendation 3:**

Extension of Extended Care Paramedic (ECP) program across NSW rural or remote areas.

In NSW, the ECP program is effective, safe and of significant benefit, consistent with other models since developed. However, the area of ECP practice in NSW has been centred around metropolitan, outer metropolitan and some high-density regional areas where there has been a significant volume of low acuity workload, higher aged care and important issues of access block in the areas of hospitals. This practice works well in areas with significant referral networks, where synergy could be achieved between ECP attendance and access to other health care providers where continuity of care occurs for patients in the mid-long term. This has not been well extended into rural or remote areas, as these areas are often under different health care pressures, with similarly poor outcomes, but lack other support systems that would allow ECP to refer to other providers promptly.

The College comprehends that the existing ECP models would not necessarily be entirely transferable to remote, rural areas without some modification or additional levels of support to replace the services available in metropolitan areas. However, new technology, such as telemedicine or other innovative ways to augment or supplement the basic services that may be available in the area, should be able to support the transferability of the ECP model.

There is scope for Community/Extended Care Paramedic roles to be expanded in metropolitan, rural and remote communities, hospitals and health clinics, aged care and other critical primary health care settings. Expansion of these models of care could support hospital avoidance initiatives and potentially reduce costs to the health system associated with emergency department presentations. Additionally, it would improve chronic health conditions' management and reduce early entry into aged care.

Paramedics have been increasingly established in primary care over the last decade in several countries. The benefits associated with paramedics working in primary care settings include a reduced GP workload, better access to health assessment and care for patients and career development within the health care system for this group of professionals.

[53] Ambulance N. Redefining our Future: NSW Ambulance Strategic Plan 2021-2026. Report. NSW Ambulance; 2021.

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NSW Health should consider the wider implementation of Community/Extended Care Paramedic practice across New South Wales, both as part of and separate from the NSW Ambulance Service, to play a vital role as part of the health workforce in multidisciplinary teams alongside GPs, nurses, and allied health professionals as an initiative and action to address the impact of ambulance ramping, access block and emergency department.

***h)*** **Other relevant matters**

**Chief Paramedic Officer (CPO)**

**Recommendation 4:**
Introduce the role of Chief Paramedic Officer within the senior health officer roles to engage and better utilise the paramedic workforce.

The College strongly supports appointing a Chief Paramedic Officer for New South Wales. A Chief Paramedic Officer would add value when governments make critical decisions impacting their communities' health care.

Like other senior officers in health roles (such as Chief Health and/or Medical Officer, Chief Nursing and Midwifery Officer, etc.), the role of the Chief Paramedic Officer should be included as part of the clinical leadership team for health. The function should sit in a suitable governmental entity outside of jurisdictional ambulance services to fully encompass and represent all paramedics working across various health settings.

The role is critical to ensure that complex problems facing health systems can be addressed with a co-designed, multidisciplinary, interprofessional approach. A Chief Paramedic Officer would enable the New South Wales government to have an expert paramedic available to advise how paramedics could contribute to existing health systems through their unique clinical skill set and help to address some of the health workforce challenges seen across the health system, particularly around the metropolitan, rural, remote divide.

Ambulance ramping, access block, and emergency department delays are symptoms of a multi-factorial health system failure. Until state and federal governments work together to fund aged care beds appropriately, improved NDIS processes and funding to allow GPs, allied health workers and paramedics to manage patients in the community, NSW will continue to see patients and paramedics at risk.

Yours sincerely,

**Mr John Bruning**
CEO
Australasia College of Paramedicine