REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Wednesday 5 October 2022

The Committee met at 9:30.

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Rose Jackson
The Hon. Aileen MacDonald

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

CORRECTED

The CHAIR: Good morning, and welcome to the first hearing of Portfolio Committee No. 2's inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales. My name is Greg Donnelly and I am the Chair of Portfolio Committee No. 2. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past, present and emerging, and also acknowledge the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginals and Torres Strait Islanders who may be joining us today, either in person or over the internet.

Today we will be hearing from a number of stakeholders, including peak medical bodies, organisations and unions as well as emergency medicine staff specialists. While we have many witnesses with us in person, some will be appearing via videoconference today. I thank everyone in advance for making the time to give evidence to this important inquiry. I appreciate how very busy people are. Before we commence, I would like to make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings.

While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments you may make to the media or to others after you have completed your evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the Legislative Council in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days. Finally, if witnesses wish to hand up documents, they should do so through the committee secretariat staff.

In terms of audibility of the hearing today, I remind both committee members and witnesses to speak into the microphone. As we have a number of witnesses in person and via videoconference, it may be helpful to identify who questions are directed to and who is speaking. For those with hearing difficulties who are present in the room today, please note that the room is fitted with induction loops compatible with hearing aid systems that have a telecoil receiver. Finally, everyone should turn their mobile phones to silent for the duration of the hearing.

CORRECTED

Dr CLARE SKINNER, President, Australasian College for Emergency Medicine, affirmed and examined

Mr JAMES GRAY, Manager, Policy and Advocacy, Australasian College for Emergency Medicine, affirmed and examined

The CHAIR: I welcome our first witnesses. I confirm that your submission has been received and we're most grateful for that. Your submission stands as No. 16 to the inquiry. It has been processed and uploaded to the webpage for the inquiry. It is a most helpful submission and I thank you for that. It's laden with a lot of content and I'm sure it will lead to a number of questions from committee members, but you can take the actual submission as read. With that said, I invite you to make an opening statement and then, if you're comfortable with that, we'll then move into the questioning part and we'll be sharing the questions around. Just to confirm, we've got members on this Committee from the Opposition, the Government and crossbench representatives as well. We will be sharing the questions between ourselves. Would you like to make an opening statement?

CLARE SKINNER: I work as a senior staff specialist in emergency medicine at Hornsby Ku-ring-gai Hospital in northern Sydney. Thank you very much for recognising the serious and urgent nature of these complex and interrelated problems, and thank you very much for the opportunity to speak with you today. I'd also like to acknowledge the traditional owners of the lands upon which New South Wales emergency departments are located. First of all, we are here representing the Australasian College for Emergency Medicine, which is a not-for-profit organisation which is tasked with training specialist emergency physicians in Australia and in Aotearoa, New Zealand, and also maintaining professional standards in emergency medicine. It's fair to say that we've been involved in research, policy and advocacy on ED overcrowding and access block since our origins nearly 40 years ago, so we would regard ourselves very much as immersed in this space and experts around this problem. So we really welcome the opportunity to present to you today.

Access block is a situation where a patient who has received care in an emergency department and needs admission to an inpatient hospital bed is unable to access that hospital bed in a timely fashion. We define that as eight hours from the time of presentation to the emergency department. The problem of access block, which is closely related but slightly different to emergency department overcrowding and ambulance ramping, is well known and the problems have been well described now for many years. Pressures on emergency departments in New South Wales have been on an increasing trajectory for decades. We've seen a trend of increasing presentations, with a slight dip during the height of some COVID waves but otherwise a rising trajectory; and not only have we seen increasing presentations to emergency departments but we've seen the patients who present having increasingly complex problems. Those are a mix of medical and social problems.

Access block and overcrowding manifest in the emergency department but it's actually a sign of broader health system and social system dysfunction. We know that access block is harmful for patients, so we know from research that there's a 10 per cent increase in preventable mortality when more than 10 per cent of patients in the emergency department have waited too long—over eight hours—to access an inpatient bed after their emergency department care is completed. We also know from our research and from surveying our members that access block and ED overcrowding are harmful for healthcare workers. Our members, when they're asked, reflect on access block as being the biggest cause of stress, poor morale and burnout in their work.

I want to remind us all and set the scene here that we're talking about real people. Today and on Friday you're going to hear a whole bunch of stats and policy statements and targets and KPIs, but these are real people, and these are real people who need acute health care. I keep close to mind—and I want you as well to keep this close to mind—that these people are our parents, our neighbours, our friends and potentially our children. They're worried, they're frightened and they're seeking help. We also need to remember that the problems of access block, ambulance ramping and ED overcrowding have the greatest detrimental impacts on people who are already the most marginalised in our society. It's very important that we don't blame patients for seeking care in emergency departments. Instead, we should blame the system for not providing the care that they need when they need it.

Access block is a very complex problem, and I would encourage you all not to be distracted by potentially simple solutions. In particular, we are concerned that there has always been a focus on diverting low-acuity patients away from emergency departments. We can provide that sort of care better and differently, but that won't solve the problem of access block, which, by definition, relates to people who need admission to a hospital bed. Access block is a complex problem. It needs deep thinking. It needs a collaborative, multidisciplinary approach, and it's going to require complex and multifaceted solutions. Since we made our submission to the inquiry we have completed the paper which we commissioned from the Sax Institute, which we would like to table to you today, which is an evidence review of the literature of solutions to access block from around the world. James has a copy of that which he can provide.

The CHAIR: Thank you very much.

CLARE SKINNER: Again, I would like to thank you for the opportunity to speak to you. Access block, ED overcrowding and ambulance ramping are big, complex problems. But I want to also encourage you to think that these can be solved. We have a need for urgent, transformative and genuine health system reform in New South Wales. That's going to require clinicians, health service executives, politicians and communities to work together, because we need the people of New South Wales to be able to have access to timely, affordable, safe, high-quality and compassionate care when they need emergency care.

The CHAIR: Thank you very much, Doctor. That was very good. It sets the scene very nicely for us to now open up for questions.

The Hon. ROSE JACKSON: Thank you so much, Dr Skinner and Mr Gray, for coming along, and for your submission and your presentation about this incredibly important issue. You say in your submission and you said in your opening statement that access block is a symptom of a broader health system in crisis. How long do you think the health system has been in crisis? How long has that been a term that you would use to describe the situation in New South Wales?

CLARE SKINNER: The first reference to ED access block—again, the situation I have described where a patient can't receive the care that they need in a timely way because the service is overloaded—first emerged in the 1990s in the literature. I have been working mostly in the New South Wales health system, but also in the ACT, for over 20 years. When I was a junior doctor we maybe had a couple of times a month where the hospital went on what was called "bypass", where we were unable to provide timely care and offload ambulances. During my career, that's now become a regular occurrence to the point where it's actually now normal, where every shift we will have trouble offloading ambulances and seeing people in beds. We will be forced to provide care to people when they first arrive in the emergency departments in corridors and in waiting rooms. As all of you can probably relate to from your own experiences of seeking emergency care, that means it's public and it's not dignified, and it also seriously limits your ability to perform a proper medical examination, take a complex medical history and form a rapport with a patient. It's just not adequate and it's not safe.

The Hon. ROSE JACKSON: So it's gone from a couple of times a month to a couple of times a day?

CLARE SKINNER: It's constant. It has become our new normal. You'll see in the Sax report, and you'll see in some of the data in our submission, that we did have dip-offs during the heavy COVID waves, particularly early in 2020 when people stayed at home and they didn't have other respiratory problems. So I would advise you not to look at that data. But if you look at the trajectory, we've had rising presentations, rising complexity and the problem of access block and ED overcrowding, which was an every-now-and-then event but has now become a permanent state of being in emergency departments in New South Wales.

The Hon. ROSE JACKSON: It's interesting, your point about COVID, because, in a way, part of the public discourse is that there are problems in the hospitals but that's just because of COVID, or it's just because it's winter and people have more flu in winter. I am interested in your description of it not as a particular seasonal issue or particular issue related to the pandemic but, in fact, a much broader and growing problem over, say, the last decade.

CLARE SKINNER: Yes, it has been a growing problem. I think it's fair to say that COVID was the straw that broke the camel's back. We've seen examples of deferred care, particularly during the pandemic, which meant that people with chronic conditions haven't been able to access care, so their conditions have deteriorated, which has probably led to some of the pressures we're seeing more recently. But it's really important to stress that this is not a COVID phenomenon. This is a global phenomenon of hospitals, which has been growing for decades due to underinvestment, under-resourcing and poor coordination of community-based care.

The Hon. ROSE JACKSON: In terms of your description of the impact of access block on real people—I think that is, as you say, a really important part of the story here—you mentioned that we use these clinical terms like "access block", or whatever. What that means is that someone is receiving care, as you say, perhaps in a hallway or in a waiting room. What type of care is occurring there? What does that look like for that individual patient? What types of things would normally occur, say, in a room or in a more private setting that are occurring in a hallway or in waiting room?

CLARE SKINNER: I'm really mindful that this is a public hearing, which limits me telling detailed patient stories. Hopefully you'll find them elsewhere in your submissions. For example, if you take an elderly patient who's fallen at home and might have a broken hip, the ideal patient journey looks like them calling an ambulance; the ambulance being able to arrive in a timely fashion; paramedics being able to administer pain relief medications; putting them on a stretcher; transporting them to hospital; offloading them into a hospital bed; and nurses and doctors, in a coordinated way, taking a history, providing pain relief, organising x-rays, giving an anaesthetic injection into the hip to relieve pain and organising a timely orthopaedic procedure to fix the hip.

At the moment, unfortunately, that elderly patient who's fallen at home—and this has happened on my recent shifts—will often be either in the back of an ambulance—it's cold and rainy in Sydney at the moment, so that's pretty uncomfortable—or they'll be queuing up in a corridor in an emergency department. We'll try to ask the paramedic staff to help us get them into x-ray really quickly to try to get that done. We'll also be forced to listen to their chest and examine them to look for other injuries, like an associated head injury, while they're on an ambulance stretcher. That limits our ability to do a proper examination. Imagine that patient needing to go to the toilet. That's very undignified, needing either catheterisation or to be on a pan in the hospital corridor. That's not fair on people. We should be able to do this better.

This is not happening because of the emergency department. We want to provide good, timely care. We want to look after people in beds. This is happening because the emergency department is full of people whose emergency department care is completed but they can't go to the wards. Then, in turn, the hospital wards have a high number of people on them whose acute hospital care is completed. They need to be discharged either back into community care or community services but there are simply no places available, or the processes are dis-coordinated and not integrated, so it's very hard to arrange that care in a timely and effective way.

The Hon. ROSE JACKSON: I think that description of someone who has fallen and injured themselves, and the way that the current arrangements would be very difficult for them, is very relatable. One of the things that you have also talked about, for example, in a media release, is that there can be even more adverse outcomes, including death. You mentioned that some of your research indicated that there was a 10 per cent increase in mortality, I think you said, as a result of the current crisis in the hospitals. How does that occur? As I said, we can all understand that it is very undignified and unpleasant for someone to be treated in a waiting room or in an ambulance. How does that then manifest into a very serious situation because they're unable to access a hospital bed in a timely way?

CLARE SKINNER: Imagine this patient is turning up to an emergency department with, say, 20 beds, for example, and all those 20 beds are already full of people. They've been worked up by the emergency department doctors and nurses and they need admission to the wards. They're now there and the emergency department doctors and nurses are still attempting to care for them while maybe caring for 30 or 40 people in the waiting room, and also caring for people down the corridor or potentially arriving in ambulances. Part of this is distraction, that we've simply got staff doing too much for too many people at once in a poorly controlled environment. You just ricochet around the department trying to make sure that nothing is going wrong. You can't do anything in a proactive or systematic way.

The second reason is—and we tend to forget this—people who work in emergency departments, all the clinicians and even the clerical and technical staff, receive training in providing that acute episodic care. We don't particularly have skills in longitudinal ongoing care. So when people get stuck in the emergency department for 12 or even up to 24 or 36 hours after they've presented, we simply don't have the skill set for that sort of care. We are specifically trained to provide that emergency-level care at the start. We want people to go to the wards not because we don't want to look after them—we want everybody to feel welcome and looked after—but simply because the skill set for those people with those sorts of care needs is actually in the ward-based environment, not in the emergency department environment.

The Hon. ROSE JACKSON: I am directing these questions generally. Mr Gray, feel free to jump in whenever you have something to add.

JAMES GRAY: One additional risk that I think is quite important to be aware of is the waiting room itself as an area of risk. If the beds are full and you've got dozens of people in the waiting room—potentially undifferentiated patients—the capacity of the ED to monitor them and check for deterioration in their condition is also a really major risk. We have been seeing cases of this around the country. When the ED is overloaded, managing that risk before they even get to the bed is creating a lot of problems as well.

The Hon. ROSE JACKSON: What are the risks for staff from that high-stress environment? I can imagine people in a waiting room, perhaps family members of someone who is there seeking care and who has been waiting a long time, are stressed and want their loved one to receive care quickly, as I am sure we all do. How are they reacting towards staff? Is there an increase in aggressive behaviour because people are frustrated?

CLARE SKINNER: People who choose to work in emergency departments do it because we like people and we feel a deep sense of connection to the community. It's like working with a conveyor belt full of things you can't get to fast enough, but what's on the conveyor belt is human distress and suffering. It causes enormous moral injury to be in a position where you are trained to provide care and you are not able to provide it in a timely way. We are seeing a lot of distress in waiting rooms. We are seeing people become very upset and anxious and this does manifest often as verbal and sometimes physical aggression. Emergency departments have become very

uncomfortable places to work and I do think the root cause is the overcrowding and access block, not because people are bad people.

The Hon. ROSE JACKSON: Of course. You said in your opening statement that you felt as though the consequences of access block were the biggest cause of burnout, which was an interesting comment to me because, as you say, they are difficult places to work. You can imagine that there are lots of stressors and pressures on someone working in an emergency department. For that to be the biggest cause of burnout, presumably that is making retention a real challenge.

CLARE SKINNER: Yes. It's a cause of burnout both because of not being able to provide the clinical care that you want and constantly worrying that you might have missed something clinically, but also because of interprofessional tensions. So just acknowledging that other parts of the hospital are also under-resourced and also struggling with these problems and so there can be significant interprofessional tensions. It's horrible when you have an anxious person, particularly a parent or a carer of an elderly patient or someone who presented to the emergency department with psychological stress, and you are not able to provide the care they need. Their symptoms of anxiety and worry can sometimes manifest as behavioural disturbance. It's preventable if we run a better system.

The Hon. ROSE JACKSON: I am interested in the retention of staff question because I think that is quite a significant one. Is your view that if we are able do better in terms of managing access block and the pressure on our emergency departments, we are going to see a direct improvement in our capacity to keep good staff on our emergency departments?

CLARE SKINNER: A good day in an emergency department is literally the most satisfying working day you could possibly have. You have human connection and stories and you can help people and save lives—it's fantastic. A bad day is really hard work. We currently have a crisis in emergency department staffing. You talked about when is a crisis; we have a crisis now. The crisis is particularly with senior nurses. I don't want to speak for them, but there are a lot of alternatives to working in an emergency department, which is an environment where you are doing night shifts, the pay is not great, people are quite aggressive with you and you can't solve the problems and provide the care you are trained to provide.

We have a crisis with the medical workforce, particularly at middle grade, which is that trainee non-specialist level. We have seen the locum market in New South Wales go out of control in terms of the dollars that people are claiming to do locum shifts in emergency departments. I honestly believe that if you provided good working conditions, it was resourced properly and we got rid of—there are a whole bunch of process issues here, which are deeply frustrating on a day-to-day level and impede good patient care. People are willing to work hard and people like the psychological and emotional challenge of emergency medicine, but they are not willing to put up with the current frustrations and the current lack of support and resourcing.

The CHAIR: I go to the issue of the trajectory that you mentioned in your opening statement, Doctor, which is a trajectory that has been increasing over time. Has work been done that you are familiar with which, at the commencement of that trajectory starting to increase, was identifying why it was starting at that point in time? We are here at this point now and words like "dysfunction" and "crisis" have been used this morning and in fact used quite often when referring to the matter of the state of play and state of affairs in our emergency departments in our public hospitals. In terms of where this all started, and this may be too simple a question to be answered in simple terms, why did it start where it did? Is there any understanding of that? I am trying to understand the rate and gradient of the trajectory and whether or not there is any plateauing or that trajectory is moving in any particular direction. All of that is of interest to us, but obviously it started some time ago.

CLARE SKINNER: The Australian Institute of Health and Welfare runs pretty detailed emergency department stats, as does the BHI in New South Wales. I am not an epidemiologist around emergency departments. The types of patients we see has changed markedly during my career. If you look at your television view on what happens in emergency departments, it's car accidents and strokes and heart attacks. In fact, the vast majority of what we are seeing at the moment is a lot of elderly care and a lot of people with mental health problems. We are also seeing a lot of people with drug and alcohol problems.

The group of presentation that is most on the increase in New South Wales is actually children and adolescents with mental health problems. That is the group that has the fastest growing trajectory. Some of this is the natural shift in the population, with the ageing of the population. We have done well with prevention and with acute health care and some other groups. For example, in my parents' age group, if you had a heart attack, you had a fair chance of not surviving. These days you would survive but you would then carry a burden of chronic illness into older age.

We have shifted the burden of health in New South Wales. The types of patients we have, have different types of problems. I think we have also seen a shift in the framework around some complex social issues. Things that were framed as maybe legal issues or social issues are now framed as health issues. I think that is a good thing because I think it comes with a more recovery-oriented and compassionate approach to the health framework, but we haven't adequately resourced the health system to absorb some of that from the social care system and from the legal and justice systems.

The CHAIR: Specifically, emergency departments as the entry point, in particular.

CLARE SKINNER: It feels like—sorry, I am talking a lot, James. I will give you a chance first.

The CHAIR: No, please continue.

CLARE SKINNER: It feels like at the moment all roads lead to the emergency department. If you are found intoxicated on the streets, it's no longer a police matter and you are brought into the emergency department. Drug and alcohol issues have become an emergency department issue. If you think of social care and a child in formal care, if they have a behavioural disturbance after hours, they are brought to the emergency department.

The CHAIR: Sorry, I missed that. What sort of disturbance?

CLARE SKINNER: A child in out-of-home care who has a behavioural disturbance will be brought to the emergency department. It's good—a health framework is a good thing there, but we haven't done the adequate resourcing for that shift away from other services. I do feel we have cut back greatly on all forms of community and social service to the point where the emergency department is the only thing left. It's the only place that has no wrong door, is open 24 hours a day and is free at point of care. Unfortunately, emergency departments are not infinitely elastic.

JAMES GRAY: I would also add that, in terms of why that curve hasn't been changing, the vast majority of attempts to address access block and, indeed, ambulance ramping has focused on the ED or on paramedics and the ambulance service, when the problem is actually further along in the system. Of course, emergency departments have a role in making sure that they work efficiently and do the best they can, but that well is dry. We have had such a focus on EDs but we need to look more broadly at the system.

The Hon. EMMA HURST: Thank you both for coming in today and providing your evidence. I have a couple of specific questions about your submission, which was really useful. Thank you for that. You mentioned other transport services in the submission, such as air ambulance and helicopter rescue services. Do you see the same problems with ramping and access block occurring for those transport systems as well? Is it the same thing that's happening or is it slightly different?

CLARE SKINNER: Look, it's slightly different. It's hard to comment specifically on that because it's just coordinated in a very different way. With most of the retrieval and air transport services, they're coordinated at a regional or even a State-based level, which means there is a little bit more resilience in the system. Also, a lot of work goes into preserving those resources to make sure they're available. But we do know of times when no air transport option is available for a critical patient. The rural inquiry last year presented some examples of that, which you will be aware of.

The Hon. EMMA HURST: Absolutely. Thank you. You also mention in the submission that there is a perception that walk-in patients are treated with a lower priority than patients arriving by ambulance. I just wanted to get a bit more information about what's happening in practice and whether you feel that it's discouraging people from self-presenting in hospitals?

CLARE SKINNER: There is a KPI on transfer of care from a paramedic to an emergency department. There are KPIs on walk-in patients, but they have less urgency in the hierarchy of KPIs that apply to emergency departments. I think we all do our best to look after anyone, regardless of their problem and regardless of their acuity. We try not to patient blame, we try not to turn people away, we try to do the best we can with the resources we have. But I think there is sometimes a perception by the general public that if you call an ambulance you will get in straightaway whereas if you walk in you will then have to wait in the waiting room. That's mostly because in the waiting room you can't see what's going on behind the scenes.

The Hon. EMMA HURST: Absolutely. Another thing you say in your submission is that in order to increase the capacity of hospitals and alternate care environments, inpatient and community services must be extended outside of normal business hours. Can you explain why they're currently only provided in business hours and what other limitations might be around that?

CLARE SKINNER: Yes, I can talk about that in the hospital setting and maybe James can do the community, which is more his area of expertise.

The Hon. EMMA HURST: Great, thanks.

CLARE SKINNER: The emergency department is open 24 hours a day. We tend to work in three shifts: a day shift, an evening shift and the night shift. We have slightly fewer staff on the night shift than on the other two shifts. It's easy to assume that emergency department presentations are chaotic and have no pattern, but they do have a very predictable pattern. The presentations tend to increase from about 10 o'clock in the morning, they peak between 3.00 and 8.00 in the evening, and then they come down through the evening, lowest in the middle of the night. The reason the night shifts are currently busy in emergency departments is because of lack of capacity during the day. So the patient numbers build up and then it's often standing room or sitting room only for anyone who is admitted during the night shift, with minimal staff on.

Part of the problem we have is that the rest of the hospital, excluding some services—for example, acute obstetrics and the intensive care unit and people on call for trauma such as orthopaedics—they go down to skeletal staff, many of those other services, after 4.30 in the afternoon. There is really good evidence that you shouldn't do a planned surgical procedure after hours; you will do a much better job when everyone is rested and the full team is present. But it means that there can be delays accessing care. So, for example, if I see someone in the emergency department, they need some physio input and they need to see a pharmacist to have their medication sorted out before they can go home and that's only available during business hours—and even then, particularly with allied health, if those people call in sick there is no replacement for them, so there is no resilience in the system—that means people can wait for days, just waiting for some things that are absolutely routine and need to be provided on a more recurring basis.

JAMES GRAY: In terms of looking outside the hospital system, it would be ideal to be able to refer people quickly into other services. An example might be in mental health. Those patients are a relatively small proportion of those that do attend the ED, but they have the highest levels of access block. But then there is also a group of patients which could be discharged back into the community with appropriate supports. It is just the way our society is structured, our economy is structured; we tend to just work within fairly set hours. That just doesn't match with health needs.

CLARE SKINNER: Another point about the hospitals is the vast majority of care in public hospitals is provided by junior and training doctors, not by qualified specialist doctors. We're different in the emergency department. We do tend to have a specialist presence there from eight o'clock in the morning until midnight or just after midnight, which means that you get senior input into decision-making. In the rest of the hospital, you often get your care provided by someone who is recently out of university, who is a trainee. They provide very good care and they are very dedicated, but people can often wait days for a specialist-level decision, which can be a major hold-up as well. There is a body of work—I think we need to increase capacity throughout the system, in all parts of the system, but we also need to make sure our processes are effective and that the right decisions are made first time. That's for good patient-centred care, but it's also so we use our resources really wisely.

The Hon. EMMA HURST: Thank you. You also explain in your submission that medical consultants are the only people capable of admitting and discharging a patient, and are often unable to attend to all patients each day. One of your recommendations is to implement a new role of dedicated discharge planners to assist with that role. Can you explain that model a bit further and the distinction between a dedicated discharge planner and a medical consultant? How would that work in practice?

CLARE SKINNER: The medical consultant would be a specialist physician or surgeon—a specialist doctor. They authorise the decision to discharge. So you will often find a relatively—look, this is not to criticise my colleagues, because I do genuinely believe that everyone is working very hard in the system, with limited resources and the best intentions. The junior doctors will often work really hard, but when the final decision about a procedure or a decision to discharge a patient or what sort of care is required next rests with the medical consultant, and that person's often employed in a very fractional way and only visits the hospital every now and then, it can mean that the junior doctors do the best they can, but they might predict that decision slightly wrong. Then there will be delays until the next time that person sees the consultant or has consultant input.

A discharge planner is a slightly different role. They are usually someone with nursing or allied health training who is employed in a role where they consider the person's complex care needs. They have a coordinating role in terms of lining up the services necessary both in the hospital to get that person ready for discharge but also in the community to make sure they have a seamless transition to community-based care with the types of allied health and community services they might need once they are home or back in their usual facility.

The Hon. EMMA HURST: We've talked a little bit about regional and metropolitan areas. Based on your knowledge and experience, especially around the issues of ramping, are we looking at really quite distinct issues? When we put this report together, should we be looking at those as two separate spaces?

CLARE SKINNER: Yes, I think you do need to consider the different sizes of the hospitals and the location. There are quite different problems. Again, it is really tempting with any problem like this to seek a uniform solution. I would really strongly encourage you that all solutions have to be multifaceted and involve local communities. In the Sydney metropolitan area, if the system becomes overloaded there is some degree to which you can load-shuffle around the metropolitan area. We saw this, most probably, during the height of the Delta outbreak of COVID, where we had a virtual control centre within Ambulance centrally. To pick hospitals I don't work at, say Bankstown hospital is experiencing severe overcrowding. The ambulance wouldn't take the person to Bankstown hospital, they might instead divert to, say, Liverpool or Campbelltown, if there was capacity there. Obviously, that only works while there is capacity somewhere in the system, and there can be problems with taking people outside of their local area when the specialists who are known to them, and their community services, aren't connected to the facility where they end up.

In a rural area, there is literally nowhere else to go. So if you're somewhere in regional New South Wales, the big regional centres, they have to absorb that load and they keep absorbing it. There is nowhere else to go. Say you're at Tamworth, the next place to go is John Hunter—there is limited capacity, you can't come into Sydney because it's just not patient-centred to get someone so far away from their family. Obviously, for severe trauma or someone with highly specialised needs, you do that; you transfer to where that care is. But you can't do that for routine care to the same extent you can in the city. The other thing that's important to note is that in the city there is a vast plethora of other services available which just don't exist in rural and regional areas, so there is more capacity to absorb things in the community as well.

JAMES GRAY: Very quickly, just back to your point around patient transport, air transport, that can be a significant issue in regional areas depending on the capacity with the system, which then, of course, contributes to access block within that regional hospital as well. So if it's waiting a day or two to transfer a patient, for instance, into the city, that's a significant amount of resourcing that's not available for that community at that time.

CLARE SKINNER: Just to give you an example of that, say I'm working in a resus team in a small hospital in New South Wales, the emergency department stops when there is a critical patient in the resuscitation bay. The entire team in a small hospital will be required to provide critical care to that patient. So if you've got someone from a major road trauma who presents to a small hospital, every nurse and doctor and orderly and security guard on hand will be involved in managing that one patient who has critical care needs. If that person then can leave quickly and get to a source of trauma care in the city, then that team is freed up to get back on with the less acute patients in the emergency department. But if that person waits there for hours, that entire team is then providing ongoing care in sort of a pseudo-ICU environment within the emergency department. That renders them not able to provide timely care in a proactive way to the other patients who are waiting at that emergency department. So this is a significant issue for smaller emergency departments.

Ms CATE FAEHRMANN: Thanks for coming today. In March this year we had budget estimates. The Minister told this Committee that the concept of what still causes major grief in other States—that is, ambulance block—is actually very rare now in New South Wales. Was he misrepresenting what is happening in New South Wales?

CLARE SKINNER: New South Wales does well compared to other States and Territories because we do—I just want to acknowledge the significant work that has been done by NSW Health to work through these problems, particularly the Whole of Health Program, which I hope you will be aware of. NSW Health does do well compared to other States, but it's fair to say that access block, ED overcrowding and ambulance ramping are significant and chronic problems in New South Wales emergency departments.

The Hon. WES FANG: Sorry, can I confirm that the New South Wales Government and the NSW Health system does well compared to other States?

Ms CATE FAEHRMANN: Order! Chair.

The Hon. WES FANG: I was just getting clarification as to the—

Ms CATE FAEHRMANN: You have your own time later, Wes.

The CHAIR: Please, Wes. We know that we don't cut in on each other.

The Hon. WES FANG: I was just seeking some clarification of the testimony.

Ms CATE FAEHRMANN: You can seek clarification in your own time.

The CHAIR: We know how this rolls.

Ms CATE FAEHRMANN: When the Minister said that ambulance blocking—he called it blocking—ambulance ramping or access block is very rare, that's not true, is it, in New South Wales?

CLARE SKINNER: It's not rare; it's common. But NSW Health, to give them their dues, has done some work on this that has yet to happen in other States and Territories in Australia.

Ms CATE FAEHRMANN: You said as well that there is a crisis in emergency department staffing, I think you said. Do you think that NSW Health and the Government is recognising that, by the sounds of it, our public hospital system is in crisis?

CLARE SKINNER: I do think they are rare that the system is under incredible pressure. The language of crisis is really hard, isn't it? Throughout my career I've always wondered what it would take for the emergency department workforce to break. We keep just pulling that little bit extra out of the tank, but I can honestly tell you that the kettle feels dry at the moment.

Ms CATE FAEHRMANN: Yes, a lot of the submissions that we have received for this inquiry certainly seem to imply that many staff are at breaking point, the emergency departments are at breaking point and the public hospital system itself is a breaking point. Would you agree with that?

CLARE SKINNER: I have seen senior staff, particularly nursing staff, who have dedicated their lives to caring for patients in emergency departments, say they have had enough and retire, resign or leave health care in the last couple of years.

Ms CATE FAEHRMANN: I think your submission also states the fact that hospitals are operating at 100 per cent capacity consistently and that there aren't enough beds for people to get to. That's another issue, I think, that it seems like the Government isn't responding to enough. I recall when I asked NSW Health and the health Minister about this, they rattled off numbers of beds and increases in staffing almost as though everything is fine—they are dealing with it, they are putting on more staff and they are supplying more beds. So what's not happening? Every time we ask the Government this they seem to imply that they've got it under control and they are addressing it.

CLARE SKINNER: Working in a public hospital is like playing a game of "bed Tetris". So much effort goes into getting maximum efficiency out of the beds. I think we need more beds and I think we need better processes. So we need to increase capacity and we need to increase flow. Most of that is resourcing, some of it is capacity, a lot of it is integration across the system and a lot of it is anthropological. I do think there is an acknowledgement of the problems; I don't think we've seen adequate work towards health reform. I think there is a fairly common shared vision, and it was outlined in a conversation piece only the other day, about moving to primarily community-based care. I think that's a common vision across the world, which is hospitals become smaller, the vast majority of people will be cared for in their own homes or in community-based settings. It sounds easy, but the reality is that that requires more resources, more coordination and very sophisticated digital mechanisms to be able to do that. We have been trying to shift towards that by cutbacks through efficiency and lean thinking in the public hospital system. You can't drive those efficiencies through setting smaller and smaller targets. You actually need to put the work into clinical redesign, change management and transformative health care.

Ms CATE FAEHRMANN: Yes. Just to explore this further, I visited Westmead a couple of months ago and was just shocked to hear from a senior emergency physician there who met with me along with some other staff. I was shocked to hear of the decrease in the beds at Westmead—something like 937, I think it was a few decades ago, to 550-something now. That doesn't seem to me to be a case of the Government ensuring there are enough beds in New South Wales when a patient needs a bed.

CLARE SKINNER: I think we need to do a better job of matching population needs to the acute hospital capacity and also the community care capacity. Part of the other problem we have is that we have highly specialised services in a lot of our hospitals and their beds don't necessarily match patients' needs. There is work we need to do on making sure we actually have beds available that match the care needs of the patients we have presenting for care now, not the theoretical needs of patients from a decade or two ago.

Ms CATE FAEHRMANN: You said earlier as well that it is this cost-cutting ideology. This is getting to the crux of it, really. There was a decision a while ago, "Let's all care for people in the community. That will be great. It will be less on the health budget." LHDs are working towards KPIs around—they have obviously got budgets that they have to work within. Essentially they are not wanting to put or can't put more beds in. Obviously it is staffing as well, but it does come down to the fact that the budget is not allowing enough beds according to demand right now in the community. Is that right?

CLARE SKINNER: Yes, I agree. We all want that transformation of care to the community basis. That is what people want. That is what I want for myself and my family. But that doesn't happen just through driving efficiency through budgets and targets; it actually happens by doing the hard work around the clinical redesign. We are too ideological when we do clinical redesign in hospitals. We rely on good intentions and doing the right thing. We need to think hard about where the money goes, we need to think hard about the relationships between the State and Federal governments and we actually need to think hard about the rules and legislation that drives some of those behaviours because we get the system that we design.

Ms CATE FAEHRMANN: I suppose a part of all this is the big hospitals that the Government continues to invest in, wanting to put in big shiny hospitals and big new wards, but is that being matched with the right number of beds, if you like, that are fully staffed, funded and have enough staff? What I am hearing as well from the unions and from nurses is that the some of these wards can't even open in these hospitals.

CLARE SKINNER: We've had a tremendous infrastructure spend in health in New South Wales over the last several years. It is welcomed and it was necessary, but there is no health care without trained, skilled healthcare staff. We need to have concurrent investment looking after that staff.

The Hon. WES FANG: Thank you both for appearing today and providing some insights to the Committee. I wanted to take you to your submission first. I note that the submission itself was written by or has the name of Dr Trevor Chan. He has obviously put the submission forward and I note that he is the chair of the New South Wales faculty. But I note also that your head office for the college is based in Victoria, so I imagine that you have some experience across the whole of the country with this issue. Can you provide some insights to the Committee about how other States are perhaps experiencing the same issues, noting that you actually provided Ms Faehrmann with some feedback about where New South Wales is—how it is that we are in relation to some of the other States?

JAMES GRAY: This is a national problem. Indeed, it is actually a bi-national problem. We also work in New Zealand as well. I think Clare mentioned earlier that around the world we are seeing these types of issues occurring. New South Wales is not unique in these problems. I refer back to my previous comment, though, that unfortunately too many of the solutions that have been put forward right across the country continue to focus on the ED and on ambulance, rather than the broader system capacity.

CLARE SKINNER: I'm the bi-national president of the college. I work very closely with Trevor, who is the New South Wales faculty chair. Because I'm based in Sydney and have a bit of experience with similar inquiries around the country, I chose to come today. Trevor was working.

The Hon. WES FANG: Sorry, when I say that, I was just seeking to point out that there's been a lot of input from your organisation.

CLARE SKINNER: That's fine.

The Hon. WES FANG: I was hoping that, given the multiple inputs, there might be some experience as to other jurisdictions as well.

CLARE SKINNER: It's fair to say New South Wales does have some strengths in this space. First, I think the problem has been well recognised by the creation—there's been a focus on ED and general hospital patient flow through the Whole of Health Program in New South Wales. We do have the advantage in New South Wales of the LHD structure, which means we're fairly well integrated. But we're not so well integrated into primary and community-based care, which is a challenge for all of Australia. We do have an advantage in New South Wales in that we use a common electronic medical record, so we have some data that's visible. That is not the case in other States. I would say New South Wales is probably best in terms of monitoring and data on this problem. We are probably the best in terms of having a centralised, coordinated program attempting to address the problem. We are equal to the other States in terms of having the problems across the hospital-community interface with how we integrate and work well with general practice and especially residential aged care. Those problems are not unique.

I would say the other State that's doing well in this space is Queensland, which also has an active program looking at patient flow across its hospitals. It also has a similar regionalised structure. The thing I do think they do better than us is recognise that you need people with experience in change management and business cases embedded in the emergency departments. As James said, a whole bunch of the focus on fixing access block has been on fixing the emergency department. I think we've done most of the things we can do. What we need now is some expertise in terms of engaging the rest of the hospital and working better across that ED community, ED hospital interface. I really like the business change managers who are embedded in some of the large Queensland emergency departments. I think that's a very good model.

The Hon. WES FANG: I note that the regional health Minister, Bronnie Taylor, often says that if the solutions were simple we would've done them already. The fact that you've provided the insight that this problem isn't just in New South Wales, it isn't just in Australia and it is, in fact, worldwide, points to there not being a simple fix to this but probably more than one and quite complex. Would that be a fair assumption?

CLARE SKINNER: Yes, absolutely.

The Hon. WES FANG: Given that we do know that the issues exist across the world, have you had the opportunity to perhaps look at some of the other systems around the world that have done work in this space? I note, for example, in the UK they've got a similar issue. But there's a Leeds model, which I've done some reading on, where they've been able to reduce their ramping issues to about one-quarter of what the UK seems to have across its nationwide network. Are you able to provide some insights as to what some of the other jurisdictions are doing? What are they doing well? What lessons have been learnt out of that that either have been employed by NSW Health or could be looked at in the future?

CLARE SKINNER: The paper we tabled earlier from the Sax Institute does exactly that. It's a literature review of international solutions to access block so that should provide some answers. In terms of where is doing well and where is doing not so well, Australia is middle of the pack. There are the systems like Denmark, for example, which has completed the transformation to community-based care, but it doesn't have the same emergency department-type system as we do, so it's not so easy to equate it.

I'd be very cautious of solutions from the UK, which has a very, very different structure in that all general practice is public. They don't have the Federal-State divide we have between acute hospital and primary and community care in the NHS, so the solutions don't work quite as well. You might have heard of NHS 111, where someone can ring and can have their call coordinated and directed to an appropriate service. That's far harder than the Australian environment, where we don't have general practice enrolment and we don't have general practice under the guise of the State. So it's much harder.

If you want to look to where is doing really badly, I would suggest that you read some papers coming out of Canadian emergency medicine at the moment. They're starting to close rural emergency departments in Canada because they can't staff them and they can't provide safe care. That's a place that's doing badly. It's pretty equivalent to Australia.

The Hon. WES FANG: The only reason I raised the Leeds model was because I started down the rabbit hole of looking at perhaps how New South Wales compared to, say, Victoria, where your head office is located. I imagine that you would have quite a detailed experience on the Victorian experience with this issue, compared to New South Wales. Then I started looking at what Victoria is doing around that space. Obviously, they have started some work around adopting that Leeds model, which is where I picked up on that.

CLARE SKINNER: Yes, I forgot that. I didn't get to it. In terms of the Leeds model—which is rapid offload of patients who present by ambulance to the emergency department to a specialised ambulance offload zone—we're really worried about that because it takes people you haven't met before, whose problems aren't differentiated, and it puts them into a poorly-staffed pool. You would be far better off to find a solution for the people who've completed their ED assessment, whose problems are described and their care has been commenced, and find somewhere to temporarily house them with staff behind the emergency department, than to create a model like the Leeds model, where you offload people who haven't yet been assessed or managed or had their treatment commenced by an emergency department doctor or nurse.

The Hon. WES FANG: In that instance, do you think the Victorian Government's decision to try to model some of their changes around that solution is perhaps not as beneficial as, say, some of the changes that the New South Wales Government has adopted to try to resolve that issue?

CLARE SKINNER: I think we all want ambulances back on the roads, able to provide emergency care to people who need their help, but we're very concerned about models where you rapid-offload undifferentiated, untreated patients into an emergency department that doesn't have capacity to admit them. We would far prefer that you created a model where you can transfer people who have completed their care out of the emergency department to free up beds for those new patients when they arrive.

The Hon. WES FANG: We know that workforce has probably been one of the biggest challenges that we face with the health sector, not only during the pandemic but coming out of the pandemic, because for a long time we had the opportunity to bring trained professionals into the country. The tap was closed during the COVID period. Is it fair to say that some of the models that we've got now in relation to attracting and retaining staff perhaps won't see benefits for years—perhaps decades—given that there's obviously an amount of time that you need to be trained to either be an ED specialist or even a nurse or an allied health professional in an ED setting? It's not a quick fix. We can't just turn the tap and fix this ramping issue tomorrow.

CLARE SKINNER: No. At the top end of the workforce, at the highly skilled end of the emergency department workforce—and that's in both medicine and nursing, and also in allied health and also the clerical and technical staff—it takes eight to 10 years to train someone to be competent to work independently. Where there's low-hanging fruit there, though, is—so, for example, my shift on Monday evening, I'm making beds, I'm getting cups of tea. Unfortunately, I couldn't find any cups, so I'm going to the storeroom. I'm doing all of that. I'm answering the phone. I think there's low-hanging fruit here in providing some support staff who can provide some of those more basic bedside-care tasks and some clerical and technical support, like stocking trolleys and cleaning and making beds, for example, so you can free up the highly trained clinicians that we do have to do some of that more clinical work.

JAMES GRAY: I would also note that, of course, immigration will always be one part of our workforce strategy. But Australia has the capacity to train nurses and doctors to a very high level. That should always be the basis of our workforce strategy. International people coming over would always be an adjunct to that.

CLARE SKINNER: It's also important to stress that the loss of workforce we're seeing now is not just due to breaks in immigration patterns. It's also because there's an enormous trend at the moment for people to decrease their working fraction, so long-term part-time has become very common.

The Hon. WES FANG: Noting the time, Chair, I just wanted to ask one last question if that's alright.

The CHAIR: You've still got four-and-a-half minutes because we've sort of gone over.

The Hon. WES FANG: I'll only ask one more question to try and bring us back on time. I just wanted to ask a question around training itself, and obviously, Mr Gray, you've indicated that one of the solutions is that we do train more doctors and that we have the capacity to do so. But, Dr Skinner, can you perhaps provide some insights as to, where you've got a senior clinician who is responsible for the oversight of that trainee, that does provide an additional burden on the senior clinician, doesn't it, in the short-term and that does create additional stress where you've obviously indicated that perhaps some of that workforce is stressed. So that's where we need to provide assistance around that training, isn't it. It's to those senior clinicians who are responsible.

CLARE SKINNER: Yes. Training is very much part of a senior clinicians role, and it's an enjoyable and satisfying part of their role. It's very, very hard to provide adequate training in an overcrowded emergency department. It becomes far easier to do a procedure yourself rather than spend the extra time to supervise a trainee doing it.

The Hon. WES FANG: See one, do one, teach one.

CLARE SKINNER: No, we don't do that anymore, but thanks for the suggestion. Trainees are a vital part of our workforce. In emergency medicine, we do run a very heavy junior-to-senior ratio. So, for example, one senior clinician will be supervising eight to 10 junior staff. No other specialty works with quite that ratio. We've been told the emergency medicine workforce is oversubscribed for years, but that all relies on that very junior workforce where the vast majority—if you go to an emergency department, you're likely to see a junior doctor with the senior doctor only providing some supervisory input. You go to a GP, you see a consultant. You go to a surgeon, you see a consultant. So we need to actually think about making sure we have a sustainable workforce pattern as well so that people aren't burning out because of the supervisory burden. It is a pleasure though mostly.

The Hon. WES FANG: I know I said last question, but it was just something you just said then. I was being facetious when I said, "See one, do one, teach one." I spent a lot of time around medical fields, so it's sort of one of those things that just rubs off. When you said that "we don't do that anymore", I think that's also part of the issue, isn't it?

CLARE SKINNER: I think we just don't have time and space for training. Everyone is just seeing the next patient on the list over and over and over again. You need to make sure that you roster people and employ people in numbers that there's adequate fat in the system for them to teach and train the next generation, to attend to their own continuing professional development and also to undertake quality improvement activities, which are vital for the ongoing care of patients.

The Hon. WES FANG: Thank you so much for appearing. Your insights have been really valuable today.

The CHAIR: Thank you very much. I have to say, that was a whirlwind tour but a very, very detailed tour of emergency medicine and a range of factors and I think a brilliant way to start the inquiry to have such eminent people who've got such detailed experience being able to go through this in so much detail. On behalf of the Committee, thank you very much. There may well be some questions on notice or perhaps more likely supplementary questions arising from members having an opportunity to read *Hansard* and particularly some of

the answers you've given to some of the complex questions. Our Committee secretariat will liaise with you in regard to that. Once again, thank you very much; it's much appreciated.

CLARE SKINNER: Thank you very much for the opportunity to speak with you today.

(The witnesses withdrew.)

Mr JOHN BRUNING, Chief Executive Officer, Australasian College of Paramedicine, affirmed and examined

Ms MICHELLE MURPHY, Advocacy and Government Relations Lead, Australasian College of Paramedicine, affirmed and examined

Mr CHRIS KASTELAN, Paramedic on Central Coast, and President, Australian Paramedics Association NSW, affirmed and examined

Mr SCOTT BEATON, Station Officer, Central West, and Vice-President, Australian Paramedics Association NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: Good morning to you all and thank you very much for making your time available today to join us for our hearing. I appreciate that you're very busy individuals and had to carve out some time for us, so thank you. Can I commence by thanking both organisations for your submissions in the first instance. The Australasian College of Paramedicine, your submission is submission No. 28 and has been received, processed and stands as a submission and therefore evidence to the inquiry. The Australian Paramedics Association NSW, your submission is submission No. 19 to the inquiry. It has been processed, uploaded and also stands as evidence to the inquiry. Committee members have had the opportunity to read these so you can take them as read for the purposes of understanding the background the members will have in regard to your submissions. Could I invite both organisations, one representative from each, to make an opening statement, and if you're okay with that, we'll then move to questions from members. We'll start with the college. Who would like to make an opening statement?

JOHN BRUNING: I will, thank you. On behalf of the Australasian College of Paramedicine, I thank the Chair and the members of the Committee for the opportunity to contribute to this important piece of work. Our health system is no longer fit for purpose. It was built to treat acute and emergency patient presentations, and while we've continually added to it and built on, it isn't working. We have an aging population with chronic and acute health conditions that require ongoing care and management. Our tertiary hospital system is not designed to manage these patients effectively. We need to be managing the ongoing health of our community in the community, in the aged-care facility or in the home.

Ramping and access block is a symptom of inpatient hospital services unable to meet patient needs, the inability to move acute patients from emergency departments to hospital wards and the safe discharge and out-of-hospital care of patients. Ultimately, ramping and access block highlights a health system in distress, and the key issue is the inability for the community to access the right care in the right place at the right time. We're all aware of the issues of primary health care and the community access to it. I think we all know the broader solution. We need appropriately resourced, equitably distributed and universally accessible and free primary health care. That would address many of the issues facing our ambulance services, emergency departments and hospitals. If all non-life-threatening, non-urgent conditions were treated in the community—that's via a GP clinic, in the home or aged-care facility via multidisciplinary teams—and most non-life-threatening, urgent conditions were treated in larger clinics and urgent care centres, you will have gone most of the way to solving the problems with our system.

Speaking specifically about paramedicine, we became a registered health profession four years ago, but we have not been appropriately considered and embedded in the health system outside of the usual ambulance service emergency response. Paramedics are independent practising clinical experts in urgent and unscheduled care. They are comfortable treating patients in any setting, pretty much like no other health profession, and they need to be strongly considered part of the solution to deliver community health care that's required today and into the future. Thank you, and we look forward to discussing our submission in more detail.

The CHAIR: Thank you, that was a very precise and clear opening statement that I'm sure will lead to questions from Committee members. Mr Kastelan, can I invite you to make an opening statement?

CHRIS KASTELAN: Thank you, I'm going to pass that across to Scott Beaton, the vice president, for that.

The CHAIR: Sorry, Mr Beaton, I shouldn't have assumed.

SCOTT BEATON: No problems. Good morning, and thank you for the opportunity to appear on behalf of the Australian Paramedics Association (NSW) members. My colleague and I have combined ambulance experience of over 40 years. We have worked in metropolitan and regional New South Wales, and both of us are acutely aware of the ramping, or bed block, and access block. Bed block is not a coping problem; it has been a problem since before we both joined NSW Ambulance. Yes, it is getting worse but, again, it's not due to COVID; it's a result of years of failure to address the key issues in our health system.

In my 20-plus years as a paramedic, I have worked in metropolitan, regional and rural New South Wales. I have experienced extensive delays at metropolitan hospitals—up to nine hours—and most recently a three-hour ramping when on a specialist regional hospital transfer, which took a total of over eight hours to complete. These delays impact not just the patient and paramedics who are sitting or standing idle but the community in general when there are no ambulances to respond. To put it into perspective, two hours of ramping for an ambulance on a hospital transfer in regional New South Wales often means there's no available ambulance in a rural town for six to seven hours.

Our submission details how our paramedic workforce is demoralised by this issue. Two-thirds of the workforce are considering leaving the job due to burnout, to which ramping is a major contributing factor. No access to meal breaks or any other downtime results in fatigue. When a 12-hour shift with no break, nowhere to sit and eat and no way of heating a pre-prepared meal is then extended due to ramping—and then when this happens every shift—something is very wrong. This is the normal life of an on-road paramedic. This was the same pre-COVID and will not disappear as we move forward. Some successful strategies were introduced during the height of the pandemic to assist paramedics with access block, such as portable crib rooms. However, these have now been removed.

There is no magic solution to fix the problem; both long-term and short-term changes are needed to assist in easing the burden on our emergency departments. These include a complete review of the triage system; expanding the extended care paramedic and patient transport workforce; and a whole-of-health approach with more GPs, more community support networks and greater infrastructure. We thank you and hope to be able to share our experiences with you from the front line.

The CHAIR: Thank you, Mr Beaton. I'm sure that very helpful opening statement, in addition to the evidence from your submission, will lead to a number of questions.

The Hon. ROSE JACKSON: Thank you for coming along, and for your submissions and your opening statements. This is probably to Mr Kastelan or Mr Beaton to start with, but others should feel free to jump in if they would like to add something. For paramedics such as yourselves and those people that you represent, obviously with a substantial amount of experience, I think it's consistent with the submissions that you've made that ramping in New South Wales is the worst that it's ever been. Is that a fair statement?

CHRIS KASTELAN: Scott?

SCOTT BEATON: I think that it's probably at its worst at the moment, yes. Although it was bad in the early 2000s, it seemed to have been relaxed somewhat. But now it's certainly back with a vengeance, but across the whole of New South Wales. Whereas previously it seemed to be metropolitan based, mainly, it's now the whole of the State that seems to be being affected.

CHRIS KASTELAN: Yes, I would just agree with that—that certainly it's as bad as we've seen, with regular examples of paramedics with patients on their ambulance stretchers awaiting care into the hospital for many hours. Quite often it would be quite a metro-centric issue, but we are now seeing the carouseling of bed block going into regional areas, which Mr Beaton has already noted puts significant strain on what is already minimal resourcing to areas that don't have multiple paramedic crews to assist them. I would concur with Scott saying it's as bad as we've seen at this point in time.

The Hon. ROSE JACKSON: Thank you for that clarification. As I said, it is consistent with your submission and the statements that you've already made. One of the reasons that I ask is that I then want to put to you a statement that Minister Hazzard made earlier this year where he described what he called ambulance block—although I understand he was referring to ambulance ramping—as "actually very rare now in New South Wales". I put that statement to you and contrast it with the statements that you've just made about how your members are telling you that, in fact, it's not very rare; it's the worst it's ever been.

CHRIS KASTELAN: I guess the irony of that statement wasn't missed on operational paramedics at that point in time. There was significant bed block around the State, on that given day that that statement was made, in different areas. We can always look at data and strategies and processes but, ultimately, our cohort is a group of people, and I think the previous submissions have stated that it is the professional individuals that keep the systems together. We advocate for those people and, by default, we advocate for the patients that we see when we go out there. Bed block is a significant concern for us at this point in time; it's been an ongoing concern. We've reiterated the dire diagnosis of bed block at the moment. We acknowledge that there's no simple answer to that, but we are certainly here and thankful for the opportunity to provide some clarity on our perspective.

The Hon. ROSE JACKSON: We might get to some of the potential solutions or responses in a minute, but I want to draw you out on this because I think it is necessary to first establish the nature of the problem. It's clear from your submission and from that statement from the Minister that the Government doesn't understand or

accept it's a problem. He described it as "very rare", and you mentioned that the irony of that statement wasn't lost on your members. The feedback from your members to comments like that—that it's very rare, that it's not a problem in New South Wales, that it's perhaps just a COVID thing or just a winter seasonal thing—is that that's just not true, isn't it?

CHRIS KASTELAN: From our members, that would be correct. We'd recently done a survey, and 80 per cent had stated they waited over four hours in bed block in the last 12 months. Was every paramedic stuck in bed block for that period of time on that day? Probably not. But it certainly was an issue on that day, and the feedback we got was that that wasn't a realistic statement from the coalface.

SCOTT BEATON: On the day that the Minister made that comment, our Facebook page lit up with photos from the day showing the bed block at varying hospitals around the State to obviously highlight that he was incorrect in making that statement. It's a daily occurrence; it's not a rare thing.

The Hon. ROSE JACKSON: Good. Thank you. So we've established, at least from what your members are telling you, that it's a real problem. I next want to move to some of the consequences of that problem—the impact that the ambulance ramping is having on patient care. In your submission, there are some pretty horrific stories about patients whose care was seriously compromised because either an ambulance wasn't available or they were stuck in an ambulance and unable to get the best-practice care in an emergency department. I think that really goes to the point that you and others have made: It's not just about statistics and data; it's about real people.

There are stories such as patients with shortness of breath waiting 40 minutes for an ambulance to arrive, subsequently having a cardiac arrest and being pronounced dead; a patient who was hit by a car waiting on the side of the road for 45 minutes; multiple patients having heart attacks waiting for proper care in bed block; and paramedics doing CPR in hallways in front of other patients to try to revive patients. Those stories are very horrific. Would you say that they're very rare? Have you picked out the worst of the worst? Or would you say that, in fact, those stories are becoming more common? Give us a sense of the frequency of those kinds of stories in New South Wales.

CHRIS KASTELAN: Whilst I don't have my finger on the pulse—pardon the pun—on all of the cases across the State, certainly those issues have been submitted by our membership due to the significant concerns that those members felt on behalf of those patients and the delays that were seen. Yes, I've heard of those stories. I've potentially been involved in similar stories like that over the years. Our concern in regard to delays and ongoing response time delays to get to our patients is that these occurrences can and will happen. In regard to whether it is happening more often, I would suggest that the population growth, our aging community and the comorbidities of care out in the community, and of illnesses in the community, would suggest that these are becoming more prevalent. And we need a fit-for-purpose paramedic workforce with suitable resourcing to get to them and attempt to give them every opportunity at the best clinical care.

The Hon. ROSE JACKSON: I want to invite Ms Murphy or Mr Bruning to comment as well. The adverse impact of ambulance ramping on patients, is that something that you have views on as well?

MICHELLE MURPHY: Yes, thank you. If I could make a comment, I think there's plenty of research and evidence out there that is demonstrating that patients waiting for care have worse outcomes. In our submission we presented some data from New Zealand and from Australia that shows poorer health outcomes. Our previous colleagues from the college of emergency medicine talked about the aging of our community. So they're living with chronic health conditions. Therefore, they're more complex and, therefore, the complexity of those conditions needs to be treated. So when there are delays in treating those, then there are worse outcomes as well. Our experience is the same—that patients are deteriorating. And that's not just a poor health outcome or death for our patients but it's the impact on our colleagues and our doctors, nurses and paramedics who are trying to look after these patients and who, because of the systems that we're working within, are inhibited from being able to provide best care. That's why we come into this profession. Having spent 27 years myself as an intensive care paramedic, we want to look after patients. We want to deliver best care. We're driven to do that. At the moment, there's this structural system that's not allowing for that to happen and the consequences are felt by both our patients and our staff and colleagues.

The Hon. ROSE JACKSON: I might just ask one more question and then invite my colleague Mr Donnelly to ask some questions too. There is sometimes a little bit of commentary in the media, which is encouraged by government, that it's the fault of patients—that patients are calling ambulances for silly reasons like they have a blood nose or they want to get some kind of relatively minor treatment done quickly, and so they just call an ambulance. Is that your experience? Is this a problem because it's the patients' fault and they're the ones calling ambulances for silly reasons and chewing up resources that should otherwise be going to those more serious cases that we've identified—people waiting on the side of a road after a car accident and people with

breathing problems? Or is it, in fact, not the case that patients are chewing up resources unnecessarily but are calling ambulances because they genuinely need urgent care.

MICHELLE MURPHY: If I could start by answering that question, this is absolutely not the patients' fault. We are responsible to provide health care for our communities and we pride ourselves on providing great health outcomes in those communities. When patients can't get the care they require or they don't have access to or the availability of that care, then they seek alternative sources to get the care from. They're not the experts in health care. They're not the experts in the services they need—we are. So they will tap into the most available service that's at their beck and call when they need help. For them, they don't know the difference between a life-threatening emergency—they're not trained when blood starts pouring out of your nose to know what to do. And so it's an emergency for them. Do they call 000 and does an intensive care paramedic come to something that they are overqualified to treat? Absolutely that happens. Is that the patient's fault? No. That's not the patient's fault at all. The patients that are waiting for ambulances—is that the patient's fault who's using the resource? No, it's not. It's a failure in our system to provide access and availability of the health care that our patients and our communities need in the time they need it.

The CHAIR: Thank you. My question is to both organisations but the question specifically presents itself in a comment within the Australasian college's submission. Specifically, it's under recommendation 1 but the sentence is the one I want to particularly comment on. Before I go into the question itself, I think a number of people outside medicine and health as professionals, or people even on the edge of it, would be surprised by this statement. It states in the second paragraph, "Aged-care facilities must provide holistic care to deliver palliative and end-of-life care in the home or facility."

It doesn't matter who answers the question or there might be multiple answers. One just assumes that particularly facilities are where many people enter into and ultimately end their life. That may be quickly or that may not be, as the case may be. And, of course, when someone is getting towards the end of their life, I'm informed by doctors it's pretty predictable, particularly in the last seven to 14 days. Death occurs regularly, or potentially regularly, in these types of facilities. But I've heard time and again—and this is suggested in this sentence—that, in fact, in a number of instances from these facilities, people quite close to the end of death are transferred to an emergency setting via the emergency department in hospitals in quite significant numbers. In other words, it happens quite often—ring 000 and get the ambulance. Would you care to comment on that and the extent to which this does happen in either residential or aged facilities?

JOHN BRUNING: I will start, given it was the college's position. My opening statement touched on the challenges that our health system has where it's really geared—the hospital system particularly—to acute and emergency presentations, and we have this aging population. And so we're forever going to fill up the hospitals. We can build more, and we did need more, but the beds are just going to end up being filled up because these people at their end of life require some more care than is generally available in an aged-care facility. But do they require emergency acute care? Yes. If you've had a fall and broken a hip, yes, you go to hospital as an aged-care resident. But we need to be able to get people back out of hospital to their home, to their aged-care facility, where there is holistic complementary care to take them through to their end of life. If we're going to put every aged person into hospital, we are going to have a problem.

The CHAIR: At the end of their life.

JOHN BRUNING: Yes. That's where we need to work out a system. Where our ideas of solutions are is that if we have multidisciplinary teams—that is doctors, nurses, paramedics, allied health—able to provide a more complete care for the aged and people in those facilities and in their home as well, we can treat them there and keep them there longer, to the end of their life, preferably. I don't know how many people feel that they want to die with tubes out of them, looking at strip lights in a hospital. I think they'd prefer to die in their home or in their facility, around their friends and family. If our solution is everyone goes to hospital then it's going to be full and the care that people expect and want isn't going to be there. That's where the solution needs to be. We're talking about community paramedicine. We're talking about innovative models of care. We're talking about what does our community need to age respectfully, gracefully, and die comfortably.

The CHAIR: End of life. Yes.

JOHN BRUNING: Yes. That's really important. We've heard from the College for Emergency Medicine, "Build more hospitals and more beds and more flowthrough." We actually need to stop taking so many people to the emergency department. We need to treat them in the community. We need the health professionals working together as multidisciplinary teams and deliver complete care to take care of our community effectively.

MICHELLE MURPHY: If I could add one point to just raise a matter, it goes back a little bit to what Ms Jackson was saying earlier: Our aged-care workers currently in these facilities are human beings as well.

They're treated to a skill set. When they get to the end of their skill set and ability, they panic or they worry or they're not sure what to do. When they can't access primary support or GP support or after-hours support, they call an ambulance. When the ambulance can't—

The CHAIR: Even RN support.

MICHELLE MURPHY: Absolutely. Exactly. Even when the ambulance gets there, if there isn't the primary care or the ability to prescribe antibiotics, or the ability to do any of those kind of small tests that could be done with a team of people that could come and visit and support that patient to stay in that facility, then they take them to hospital because they know they need an X-ray or bloods done or antibiotics. All of these things can be provided in the facility if there were the access to those kind of tools and specialist skills within the facility in that primary care setting.

The CHAIR: Can I just hear from the association in terms of practical experience?

CHRIS KASTELAN: Sure.

The CHAIR: You may not be able to reduce it to a percentage of visits to facilities in any given day or week but just as a general observation.

CHRIS KASTELAN: Do you want to start off, Scott?

SCOTT BEATON: Yes. In respect to a lot of the regional areas out here, the aged-care facilities don't necessarily have a registered nurse on duty at all times. In fact, quite often it's nine to five, Monday to Friday. Therefore, when a person does become ill and they have an end-of-life plan, as was touched on before, the staff only have certain a skill set, so their fallback is to call an ambulance to then assess this patient. They just want that patient out of there, and we have to take them to the hospital. There's also other issues, where you have some patients that do not have end-of life plans. Therefore we're then bound to take them because there's no way of leaving them behind at the nursing home where there isn't the level of care.

GPs putting in end-of-life plans and assisting the patients or, if they call the GP for an assessment of this patient—GPs are so busy out here. You can wait three to five weeks for a GP appointment in some of our regional communities. So the GPs just can't drop everything and get themselves down to the nursing home to check out that patient. It's a difficult situation. I do agree with the previous statements from the college. We should be looking at a greater scope of practice so that we can get the whole of community to leave these people in place, whether it be in an aged-care facility or at home. People make a decision to—they want to die at home, or they want to die in their current surroundings. We shouldn't be forced to be taking them to the hospital.

The Hon. EMMA HURST: Thank you all for joining us this morning. I wanted to start with some questions to Mr Bruning and Ms Murphy. You note in your submission that access block and ED overcrowding contributed to higher mortality rates, of 20 to 30 per cent, which is an absolutely shocking figure. I believe the data relates to 2009. I'm wondering if there's any more recent indication of the impact on mortality rates and if it's going up since that 20 to 30 per cent figure in 2009.

JOHN BRUNING: The most recent data that we had—it was also mentioned earlier; I think it's on ours, and it's come out of New Zealand—was that there was a 10 per cent greater chance of dying within seven days of admission when experiencing delays in admission. I think the College for Emergency Medicine also quoted those figures. I think that some up-to-date data from Australia would be good, but I don't have any other details of that. But that's very recent, out of New Zealand.

MICHELLE MURPHY: There is a study about to be published, out of Victoria, which looks at the quality and safety and morbidity and mortality of patients while they're ramped and waiting for entry into that emergency department.

The Hon. EMMA HURST: That's really useful. Thank you. Your submission also recommended using profiling tools to identify and track medically at-risk Australians and provide in-home services. But you note that there's currently no effective models to do this and that the current model is unsuitable. Can you tell us a bit more about this current model and how it works or doesn't work and what needs to be improved?

MICHELLE MURPHY: There's a couple of different ways of, I guess, looking at these at-risk and high-risk patients. One of the trials and pilots that's happening in a regional Victorian town is around using paramedics to go to check in on patients when they've had a procedure or returned from hospital, just to do that kind of follow-up holistic care to make sure they've the right services and access to those kind of things. That requires notification and linkage between primary healthcare networks, tertiary healthcare networks, the whole of Government, the whole of Health, which is a bit clunky and difficult. So we're advocating to look at how we can

better support these patients and how we can link in across tertiary and primary healthcare settings so that these patients are tapped in and have the care they need.

We know that if we follow up and if we go and check that they've got the right medication and they've got access to the supports they need, they don't re-present and they don't come back it into that tertiary system. But also there are complications associated with all these kind of procedures. I'm using an example of, let's say, someone has chest pain or they have a heart attack and they go in and they have a stent or they have a procedure. There's a 10 per cent risk that that stent or that procedure will re-occlude in those first 14 days. Tapping in with those patients and rechecking in on them to make sure they've got all of those things that they need is really important because it stops that re-presentation. But it also stops deterioration or impacts of side effects or consequences.

The Hon. EMMA HURST: Thank you. I've got some questions as well for Mr Kastelan and Mr Beaton. You mentioned in your submission that cars should be sent to relieve paramedic crews once they're past their finish time and stuck in bed block but that it rarely happens. Could you speak to some of the obstacles that are being faced about sending out those relief crews?

CHRIS KASTELAN: The obstacles in your question are the desire or want to follow the policy, number one, and the elephant in the room is the enormous workload that we're currently experiencing. Yes, that is a policy that NSW Ambulance does have. The reason why you would have that is to ensure that paramedics who have already done 12 hours and are entering into their thirteenth, fourteenth or fifteenth hour will be relieved so that they can—obviously after that period of time it's very fatiguing and resilience does dip when you get that long into a shift. To answer your question, it doesn't happen very regularly, even if paramedics particularly ask for it. In saying that, I'm sure there will be examples where it has happened, but it is not the norm due to the enormous workload at the commencement of the new shift. There are no cars left over to do those types of resilience roles to get them off, to get them home to see their partner, put their kids to sleep, or shower, or just focus on basic hygiene functions. So, Scott, anything from you, mate?

SCOTT BEATON: No. I agree: It does happen, but it's quite rare. If there's a large amount of jobs sitting there waiting for that next shift to come on to cover, and then they end up in the same queue as the crews that have been waiting there, waiting to finish their night shift or the day shift.

The Hon. EMMA HURST: Thank you. You also say in your submission that:

> … many members have identified improving the triaging system as a key action in reducing bed block. The current triaging system does not allow for clinical nuance …

Can you expand on that and give us any suggestions on how that triaging system actually needs improving, and how it will work in practice?

CHRIS KASTELAN: I can certainly start. I think that complements previous discussions around holistic care within the community; that we probably need to have a level of nuance within our triaging system to ensure that—and I also want to reiterate that people phoning 000 are not the concern. They are phoning because they are generally upset and concerned about their personal wellbeing. That's why they call 000. But ultimately, in the triaging system, it's a very blunt instrument. It catches a lot of patients. There's very, very high priority response times. When the paramedics get there on scene, it may not have been the case. So I guess, for us, we just want to see that the most appropriate cases are being responded in a timely manner to reduce any of those negative outcomes that we heard about a little bit earlier in our submissions around devastating clinical and personal outcomes for not only patients but it's a ripple effect to families and the paramedics that deal with this. But certainly making sure that that nuance flows down to ensure that community paramedicine becomes a big part of our trade—that we can support the community. I think that rolls onto what you just mentioned.

The Hon. EMMA HURST: Yes. Mr Beaton?

SCOTT BEATON: If I might clarify: The triage system we're talking about is the triaging of 000 calls.

CHRIS KASTELAN: Yes.

SCOTT BEATON: So when a call comes in there's a system that the call takers go through. It identifies whether or not the condition is serious. Now, this also occurs with the booking system, so the non-urgent calls that can come in for transfers, et cetera. If someone's suffering a heart attack and needs to be transferred from one smaller hospital to a large hospital, then they should be given the highest priority; but when someone is requiring an X-ray at three o'clock in the morning because there isn't one, do they really need to go from a small hospital to a big hospital in the middle of the night for an X-ray? And they're the sorts of things that we're talking about. The system is failing in that it doesn't identify the most highest priority first.

MICHELLE MURPHY: Could I make a comment, if I could, just for the benefit of the Committee here?

The CHAIR: Thank you.

MICHELLE MURPHY: I think there are two things: There is the 000 triage filter system and when you have a call centre, particularly in Sydney and Victoria which is my experience, when you have 1,500 calls coming in a day, the priority and the purpose of having a rapid ability to triage that call is to identify those patients in immediate life threat, for the call taker to be able to create an event and send an ambulance, but to provide that lifesaving intervention on the phone in that moment. So those tools—usually ProQA is the most common tool used across Victoria; it's an internationally renowned medical triage tool—you need to have a blunt instrument to filter that very quickly to be able to identify those critically unwell patients who can't wait in a queue. We've seen the recent news around ESTA and communications and delays to 000 calls, which is catastrophic.

The next part of that is, once you filter that blunt tool and you need to have a look at what that other pool of calls who take out that 1.5 per cent of true emergency life-threatening calls, and then you have those other emergency events, there is some evidence that suggests that being able to have a health professional that's trained—in Victoria we've paramedics and nurses—New South Wales developed the same tool during COVID for that triage system in its infancy; but, you know, expanding that will go a long way, which is the virtual clinical care centre. What we've been able to demonstrate is it's very safe for these patients to go through to what we'll call a secondary triage service to then spend a bit more time with the patient and say, "Hey, what's going on?", using your clinical knowledge, using some validated tools to identify the category of those patients to filter again with some life-threatening emergency questions—because some of those get missed, particularly with non-English-speaking or elderly patients—so to filter that again, but then to be able to provide advice, home care and direction to these patients.

We're seeing in Victoria 50 per cent of those patients that go through the secondary triage services, if you have appropriate alternative service providers that you can connect these patients to, don't require an emergency ambulance. New South Wales is experiencing a similar thing and so expanding that kind of service, to help patients who call 000 because they don't know what else to do when they've got a problem that needs health care, I think is really important: But, they're two separate things and both need to go hand in hand.

The CHAIR: That's very helpful. That's very helpful to know, thanks. Cate Faehrmann?

Ms CATE FAEHRMANN: Thank you, Chair. Let's just continue on that issue. That just makes perfect sense. That's just absolutely part of the solution—it's common sense. Why is the New South Wales Government not doing this? You're saying Victoria is?

CHRIS KASTELAN: They are doing it.

MICHELLE MURPHY: New South Wales is doing it.

Ms CATE FAEHRMANN: What else needs to happen because you said before that the triage system is broken. What more needs to happen then to fix it?

CHRIS KASTELAN: Well, I think Ms Murphy has provided some clarity on that: New South Wales has come in a little bit late in the piece, and it was probably COVID-prompted by that; that there was just such an enormous volume of calls coming in. We do have this VCCC, this virtual care centre, where you're right—the most important and life-threatening cases are having ambulances responding immediately, and the call takers are staying online. If the call takers believe it's a significant event, they can be referred to more paramedics or medically related people in the call centre to assist the journey on the other end because we don't know what's going on, on the other end.

But, yes, we do get to these non-life-threatening events, which make up nine out of 10 of our calls that we go to and how they can better be managed. We would hope that the model going forward is supported. The implementation of it at this point in time is we're cautiously optimistic that we can progress forward with this. We would suggest that that would be one of the strategies that we could use progressing forward to ensure that life-threatening cases are responded to in a timely manner, and lower acuity cases also can be responded to in a timely manner but relative to the incident on the other end of the line.

Ms CATE FAEHRMANN: Thank you. I'll push ahead just because of time.

CHRIS KASTELAN: Sure.

Ms CATE FAEHRMANN: Mr Beaton, I just want to get your response—and my colleague has mentioned this before—but particularly your response to the comment by the Minister, Brad Hazzard, in the

budget estimates in March this year in response to a question I asked him about ambulance ramping. This is when he said:

> The concept of what still causes major grief in other States—that is, ambulance block—is actually very rare now in New South Wales.

When you heard the Minister say that, what was your response, and what was the response by your colleagues?

SCOTT BEATON: As I said before, it was actually—I laughed, to be perfectly honest, because it was just a statement to show that perhaps the Minister or his advisers are completely out of touch with what's actually happening in the hospitals. Now, for years I know I've been at a hospital where there's a system called the matrix, which stops you from going to a particular hospital. Only a certain amount of ambulances within an hour can attend. They've put hospitals on bypass so that some sort of politician can come and visit and see that there's no hospital ramping there. That's because ambulances were denied from going to those hospitals. This is a thing that's been happening for years but the problem is out there everywhere. We've got daily pictures on our Facebook page of hospital ramping, whether it be in the Gosford Hospital, the Dubbo hospital or Wagga, Liverpool, Westmead—it occurs everywhere and it's on a daily basis.

Ms CATE FAEHRMANN: You have also said in your submission that, in fact, ambulance ramping was terrible, I think, from 2017 to 2019—I'm trying to find the exact thing, which I probably won't be able to in time—but this was going on before COVID and this was an issue that your members were raising with the Government, that things were getting worse. Do you feel like the Government has been ignoring your calls for years now to fix this problem, to get more ambulances on the roads, but also to fix the problem of access block in our hospitals?

SCOTT BEATON: Yes. As I said in the opening statement, it's been a problem in the 20-plus years I've been a paramedic. It's getting worse. We had the height of our flu seasons, where it was always bad for years and years, but now it seems to be a constant year-round thing. Instead of being seasonal, it's now a day-to-day problem that occurs. Everyone buries their head in the sand and they treat it as normal, and this is the problem.

Ms CATE FAEHRMANN: It's just extraordinary. I'm quite angry about it because it was a question from me to the Minister after speaking with your members, actually, about the extent of ambulance ramping. His response to me was that it is very rare in New South Wales. That's what the health Minister is saying to this health Committee when asked about what he is doing about ambulance ramping. It's not acceptable, is it, Mr Beaton?

SCOTT BEATON: No, it's not. And it's not been acceptable for a very long time. It's harmful to paramedics and it's harmful to patients and the community in general. We have response times that are blowing out across the board. Increasing the amounts of paramedics puts more ambulances on the road, but at the moment that puts more ambulances into bed block. It's great to have more ambulances and more paramedics, but it doesn't help when they get to the destination with the patients and they're then all stuck for hours on end and there are still no ambulances to respond.

Ms CATE FAEHRMANN: Thank you. That puts it all into a very good perspective, that last statement of yours. I want to explore a little bit about the failure of this Government to support the extended care paramedics program. You have highlighted that in your submission, and it's also something that I've asked the Government about multiple times. Why are NSW Ambulance and the Government so unsupportive of this program that clearly saves the health system money if there were more extended care paramedics and if they were supported more in regional areas? What are the politics behind the fact that the Government isn't supporting something that your members want that would save the health system money? I will go to you firstly, Mr Kastelan.

CHRIS KASTELAN: I can't speak to the politics around that; only the people involved in those decisions can speak about that. Our members are telling us that we believe it would be a very worthwhile program to be rolled out across the State. It goes without saying that having highly skilled and qualified extended care paramedics with a much larger scope of practice to provide the lower-acuity and out-of-hospital care that a lot of our community requires can only be advantageous to them.

Ms CATE FAEHRMANN: Mr Kastelan, can I jump in? My time is about to expire. I want to ask for a response on this. You have said in your submission that extended care paramedics "are routinely used to 'stop the clock' on response time Key Performance Indicators". Could you explain what that means?

CHRIS KASTELAN: An extended care paramedic has those higher skill sets for those low-acuity cases. But, to keep it short, they're quite often being used for hot or P1 responses—lights-and-siren responses—to get to higher-acuity cases to tick the box on KPIs and response times. It appears to be not the most appropriate use of those skill sets out there. We believe it's hiding a problem of appropriate paramedic resourcing and some of the issues that will come up in this inquiry.

JOHN BRUNING: At the college we are fully supportive of extended care paramedics, community paramedicine and the greater utilisation of the skill set of paramedics. But the expansion or the greater utilisation, I think, is partially hamstrung by the lack of expert paramedicine advice to government. Currently, we have a situation where if you want to know how to use paramedics better, where does the Government go? Does it go to an ambulance service, which has KPIs and requirements to hit targets and move people and get them to hospital and doing these sorts of things. Actually, you need someone independent to be able to say, "Do you know what? You can actually use paramedics in this way." The ambulance service may not wish to propose the utilisation of paramedics in different ways because it may take away from the emergency response requirement. In Victoria we have the one and only chief paramedic officer, who sits separate of the ambulance service and is able to provide advice as to how paramedics can be utilised in new, innovative and different ways. We saw through the initial start of COVID that it actually made a significant difference because paramedics were able to utilise much more widely than emergency response and to support the health system with taking care of COVID patients. We were able to leave nurses in hospital and those sorts of things.

Ms CATE FAEHRMANN: It sounds like you're suggesting that be a recommendation to this Committee.

MICHELLE MURPHY: Absolutely.

JOHN BRUNING: It's in our document.

CHRIS KASTELAN: It is. It's quite training-intense, though. For an extended care paramedic to be taken off road and to provide the clinical skills that they need to then progress out into the community is quite an intense process. Again, you can't just cook one up and have it ready to go tomorrow. It takes quite a while. So there is a delay. We've found that the ongoing training for extended care paramedics and their resourcing out to regional and rural areas appears to be difficult for NSW Ambulance to manage, because there are a lot of core skills that they need to complete pretty regularly to ensure that they are competent in those skills. We would like to see extended care paramedics, complementary to your submission, rolled out across the State to smaller communities.

The Hon. LOU AMATO: Thank you all for coming to today's inquiry. Your knowledge and input are very valuable to this inquiry. I will go to Mr Beaton first, and I don't mind who else jumps in afterwards. You were touching on aged-care facilities earlier on and you talked about registered nurses. Do all aged-care facilities have registered nurses? If they don't, if aged-care facilities had a better system in place, would that be better for the patients there? Would that also alleviate some of the pressures on the hospital system?

SCOTT BEATON: I can't comment on all the nursing homes in New South Wales. But, obviously, from experience in my area, the registered nurses who work in our aged-care facilities in regional New South Wales generally work nine to five, Monday to Friday. There's usually one registered nurse at our facility, and everyone else is either an enrolled nurse or an AIN, an assistant nurse—someone in training. Quite often when they call 000 and we go the VCCC, which was discussed before, they're triaged. But if there is no registered nurse on site then we get sent as an emergency response to check out that patient, whereas during the day when there's a registered nurse, what we've found is that they will go through a process to treat the patient in-house before sending an ambulance, if required, sometimes a long time down the track, or we aren't sent at all because that registered nurse can treat the patient as per advice from the VCCC.

The Hon. LOU AMATO: How are they treating the residents in the aged-care facilities with end of life? If a registered nurse is only there between, say, nine to five, what's happening after that?

SCOTT BEATON: After hours, if something goes wrong with that patient, they call 000.

The Hon. LOU AMATO: Then they've got to go through 000 and wait.

SCOTT BEATON: We go through the process, and quite often we're transporting these patients to the hospital.

CHRIS KASTELAN: It's entirely appropriate to go to some end-of-life cases when there is some remedial treatment that can keep them comfortable. That's entirely fair and reasonable. The end-of-life process, which is something that people don't really talk about, can be a very ugly situation that is very confronting for people who aren't in the field. Assistants in nursing, who have carriage of anywhere between 20 and 80 patients after hours, have other work-related stressors on them to fulfil their role. It is a very easy fix to phone 000 to have paramedics come out. We are very thankful for the workforce that works in aged care and provides support for our aged Australians. They do a fantastic job. They do have some clinical advice call lines that they can contact, but it doesn't actually make up for the high skills of a registered nurse on site that can be hands-on.

JOHN BRUNING: It's definitely an improvement in terms of the care to those in the aged-care facility if there is a registered nurse on staff. It would definitely reduce the likelihood of a call-out to a paramedic to come from the ambulance service. We know that the Federal Government has proposed a nurse in every aged-care facility, which I think is a good step. But we do still have the situation where, even with the nurses in the aged-care facility, once you hit the top of their scope and what they can do for that patient, they are then calling the ambulance. I think it improves the care that is provided but it doesn't provide all the care that is needed, not just at that end-of-life phase but in the aged-care facility. If you had multidisciplinary teams with a mixed skill set of doctors, nurses, paramedics and allied health, less of those transports would be required and patients would be less likely to end up in hospital.

What we haven't discussed is that it's getting patients back out of hospital as well which is a major issue. They go to hospital and you think, "They will be there for a week or two weeks, they will be cared for, they will get better and then they will go back." But you get to the point where you go, "Can they safely go back? Can they be cared for appropriately back in the facility?" If that answer is no, then that's it; they are staying. That's where a team approach of the healthcare professions working together to have a much broader skill set for everyone in that group to provide that care means that we can take some of the pressure off the hospital system.

The Hon. LOU AMATO: We have heard that before in previous inquiries, even in the euthanasia inquiry. A lot of people who are suffering go, "Look, I'd rather just get out of here. I've had enough." If they had the appropriate care at the facilities or at home or wherever it was, it would be less of a burden on the hospital system and, again, they could spend quality time with their loved ones. Another thing I heard is about bulk billing. I don't know how true this is, but I was only talking to someone about it the other day. I won't mention the area. They were talking about how a lot of doctors now are not bulk billing and that is forcing a lot of people, like those from low socio-economic backgrounds and pensioners, to go into the emergency ward rather than the doctor because they can't afford it. Have you heard that? Is that true?

MICHELLE MURPHY: If I can comment on that, I think that the funding system for our healthcare model overall is not fit for purpose. I think that it sets up people who can't get in to see a GP or the GP is no longer bulk billing to go find free health care elsewhere, and the ambulance service is free and the emergency department is free. It also inhibits the ability for local health districts and other providers to employ health professionals that don't fit inside the Medicare benefits scheme to be able to work and deliver care. That impedes the ability to employ paramedics, to employ physios and to employ other people because they will need a feepaying service.

I think there are lots of challenges in that funding model, but I am not 100 per cent sure what the answer is. I think it needs to be multifactorial and I think there need to be different pathways and avenues. The current workforce incentive scheme, et cetera, is very isolated to just a few who are eligible to be part of that system. Therefore, if you can't get a GP or a nurse practitioner in the community, then you can't have any health professional. You might have extended care paramedics and physios and pharmacists who want to come and work in the community but, because of the funding model, they can't come. The community will go without any kind of health care because our model says that it has to be a GP or a nurse practitioner because it has to be under the Medicare scheme.

We have seen corporate services, particularly in the mining industry and some larger industries, where they are the main employer of a town and there's lots of revenue and funding and they provide funding for health services that are bulk funded. That creates this ability for health practitioners and multidisciplinary teams to come in and provide excellent quality health care for the community, not just for the workers within the facilities. We have seen those be very successful, but that's because they are not reliant on one model of funding.

The Hon. LOU AMATO: That is based on a US model, is that right?

JOHN BRUNING: No, it's on the NACCHO model, which is the National Aboriginal Community Controlled Health Organisation model, where you have more block funding. We have this issue, and it's the elephant in the room, that isn't something that State governments can deal with, which is the funding of primary health care being episodic and based on Medicare. It really challenges the system to provide holistic, complimentary and complete care to the community. The example Michelle is talking about is out in rural Western Australia, which is an Aboriginal controlled health organisation where there are a lot of mining sites. There is bulk funding provided, which means that they have a complete health system that is able to provide fully holistic care. They go to homes in the night-time. It's a good model, if we could provide funding that way more universally across Australia.

The Hon. LOU AMATO: That is quite interesting.

SCOTT BEATON: If I may, I will just say that whether it's the bulk billing or not, it's just the availability of general practitioners in a lot of the communities. It can take, like I said earlier, up to three weeks to

get an appointment at the GP. A lot of people will say, "I'm not that sick. I will wait until I can get in to see the doctor." That could be two weeks away and they've got a bit of a chest infection and they progressively get worse to the point where they can't breathe and so they end up calling an ambulance and being presented into the hospital. That means that they are desperately unwell and they need to be at a bigger hospital and they take up a bed in the hospital now for a week. The ability to get in to see the doctor in an earlier time frame with some antibiotics would mean that they may never have presented to a hospital in the first place.

The lack of availability for GPs, whether that's through bulk billing or not bulk billing, is a lot of the issue that causes people to present to the hospital. Others who can't wait to get into the GP will then call an ambulance to go to the hospital or self present to hospital. Self presentations are just as big of an issue that causes ramping as ambulances bringing patients into the hospital are. You've got all these people self presenting for minor issues because they can't get into their GP. When an ambulance gets there, there are no beds because of all the self presentations. It's very much about the need for more GPs. A better funding model for GPs is part of it, which is a Federal issue.

The Hon. AILEEN MacDONALD: Thank you for your time today. In your submission, recommendation 2 is about consultation on models for temporary transfer of care options. Could you expand on that? I know you have said that there should never be long-term solutions but if you could expand on what the models might be, that would help with that situation.

CHRIS KASTELAN: Is that on the Australian Paramedics Association submission?

The Hon. AILEEN MacDONALD: Yes.

CHRIS KASTELAN: Absolutely. What I would like to say with transfer of care is that there are different models out there. It might be paramedicine based and you might have extra paramedics in the emergency department assisting with transfer of care and, in some instances, there are nurses doing that. But I think there needs to be further consultation because there can be local solutions available to some of these emergency departments that are specific to local area health districts. In one hospital, paramedics may be freely available because nursing availability is not, and vice versa in other areas. I think there does need to be a more collaborative approach. We have health relationship managers, which are people who are the conduit between NSW Ambulance and the emergency departments.

Certainly, that transfer of care is critically important, not only because we want to try to release paramedics to go back out into the field to assist with patients but because we need to make sure that they are safe as well. We were talking early on in the piece about people being left in corridors and stuff. That's plainly not what we're advocating for at all. They do need to be in a safe clinical environment as well. In regards to transfer of care, there are a few solutions available that might be specific to local area health districts. So that would probably be my answer to you on that one.

The Hon. AILEEN MacDONALD: Thank you. The other question refers to a recommendation that ACEM have put in for consistent KPIs for ambulance to ED offloading. Do you actually have any KPIs?

MICHELLE MURPHY: Yes. Absolutely. The ambulance services all have KPIs about transfer times. They're called something different: offload transfer times. I think, for these time-critical patients, speedy, timely, efficient transfer of care is critical. I think one of the broader issues though is the patients that we're transferring and where we're transferring them. We have a large pool of patients that go to ED that don't need to be in ED and could actually be transferred to other services: urgent care centres, GP clinics. Often patients will ring because they can't get to the hospital and so we have a system set up where ambulances take patients to emergency departments.

There isn't a system set up to go, you know, ambulances can—there have been some pilots in Queensland and South Australia—and Western Australia, I think—around transferring patients to other facilities: urgent care centres. Different groups will espouse there are dangers in a paramedic's ability to assess the patient and take them to the right place. There have been no deaths, no adverse outcomes, from any of these trials and studies that have safely, effectively, picked the right patients to go to the right facilities for the care that they need. I think that's really important. Paramedics are professionals. They do diagnose the patient, they care for the patient, they treat them and they're able to determine which facility can provide that ongoing care safely and effectively.

The CHAIR: That brings us to the end of the session. Sorry to take you beyond the time but I have to say your evidence was very detailed and rich and leaves us with lots of material to ponder. I'm sure there is going to be some supplementary questions arising from members having a chance to read *Hansard*. Once that's done, we'll liaise with the secretariat and the secretariat will get back to yourselves in regards to provision of responses to those. On behalf of the Committee, thank you very much. It was very good and most helpful evidence.

CORRECTED

(The witnesses withdrew.)

(Short adjournment)

Mr DAVID WATERS, Chief Executive, The Council of Ambulance Authorities Inc, before the Committee via videoconference, affirmed and examined

Associate Professor RAY BANGE, Private Individual, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you, gentlemen. We normally have people in the room and people on the screen, so we're actually looking both in the room and on the screen. But with you both on the screen, that makes it a little bit easier for us. Once again, thank you both for making your time available. We appreciate that you're very busy and had to carve out time to both make the preparation for today and make the time available specifically. Mr Waters, I understand you're coming to us from New Zealand, is that correct?

DAVID WATERS: That's correct.

The CHAIR: You're over in New Zealand, so there might be a very tiny lag. In any event, we'll take this very carefully and slowly. If we need to pause at any point, we will do. But we'll do our best to try to remediate that issue. I will invite both of you now to make an opening statement. Following the opening statements, we'll open up to questioning from committee members. Just to confirm with you, we have committee members from the Opposition, the crossbench and the Government here at the table today, so there will be quite a cross-section of questions to be directed to both of you. There is no particular order, but if we start with Mr Waters—you're first on my list—would you like to make an opening statement?

DAVID WATERS: Thank you. Firstly, the Council of Ambulance Authorities represents the 11 statutory ambulance services across Australia, New Zealand and Papua New Guinea. That accounts for in the region of 4.6 million patients being attended to annually, with about 3.8 million patients taken to emergency services. Obviously ambulance services play a critical role in the delivery of safe, high quality and timely care, providing essential emergency response services to treat patients and transport them to hospital where that is necessary.

Delays in hospital transfers of care occur where patients are unable to be transferred into the care of hospital clinicians in emergency or other hospital departments. In these circumstances, the patient remains under the care of paramedics until such time that transfer of care can occur. The cause of transfer-of-care delays are multifactorial and often not entirely in the domain of any individual part of the health system or hospital. The resolution of the causes of transfer-of-care delays—or ramping, as it is more commonly known—must be considered not just an ambulance and hospital issue but as a whole-of-health and intergovernmental, system-level problem to be solved. Transfer-of-care delays is not an indication of an ambulance service's performance rather than of a health system under systemic strain.

The time taken to complete an acceptable transfer of care varies across Australia, New Zealand and PNG. However, 30 minutes is generally the accepted measure and anything greater than that is considered a delay. We do have some instances where ambulance services do have a slightly longer window to do the transfer of care. Over the last two years CAA members have reported that their transfer-of-care delays are increasing. It's not uncommon to see periods of four to six hours where patients remain on the ambulance stretcher, and in some instances exceeding that—up to 12 to 14 hours have been reported. The transfer of care delay is an important consideration in the care of patients and it has a direct impact on patient safety.

Ambulance services have traditionally transported a patient to ED when that's required and handed that patient over there. Now they are being faced, in many jurisdictions—not just Australia but globally—with having to care for that patient for longer periods on the stretcher, which involves a different type of care to that which they traditionally provide. This also has a direct impact on their ability to respond to other emergencies in the community, which leads to patient delayed care and potential harm to patients waiting for an ambulance in their moment of emergency. I will leave it at that. I am happy to take questions when you are ready.

The CHAIR: Thank you very much, Mr Waters. That is very helpful. Associate Professor, I invite you to make an opening statement.

RAY BANGE: I recognise and pay tribute to the exceptional dedication and expertise of those working at all levels within the health system. That commitment is ever present but has been especially notable under the demands occasioned by the COVID-19 pandemic. There is indisputable evidence that the health system is under stress, which is placing both patients and healthcare workers at unacceptable risk. The consequential impacts and resulting harms are well described in several submissions to this inquiry. Shortfalls in staffing and maldistribution in the health workforce have had a profound impact on aging patient populations and those with chronic conditions and mental health issues. Past investment and reliance on tertiary facilities means that hospital emergency

departments have become major 24-hour entry portals for general as well as emergency and unscheduled health presentations. The result is highly visible bottlenecks with ambulance ramping, bed block and hallway health.

At a national level, a greater focus is now being placed on primary and preventive care. These developments need to be considered in framing the effective use of the available health workforce when it comes to the delayed handover of patients. An expert and available workforce is the key to effective health care. While the terms of reference of this inquiry are very broad, I have therefore focused attention on the sustainability of the health workforce and the current and future role of paramedicine. The submission emphasises the interconnected nature of health care and the gatekeeper roles played by ambulance services and primary care providers. I discuss how paramedics can support primary care and thereby potentially reduce the input demand for emergency department and hospital care. The recommendations I have made also outline mechanisms for the avoidance of ambulance transport to emergency departments to thereby reduce the incidence of patient offload delay.

I provide a snapshot of paramedicine as an under-utilised health profession and how the legislation and regulations pertaining to paramedic practice have not kept pace with the rapid development of the profession and expanded practitioner capabilities. I suggest that consideration of paramedicine has revolved around the ambulance services, with inadequate consideration of the paramedics who work outside of those organisations. This ambulance-centric focus creates uncertainty regarding the legal status of private paramedic employment and inhibits the use of paramedics in other areas of health. Paramedics already can be found in GP clinics and hospital emergency departments, but their engagement is sporadic and the profession is ignored for funding and Medicare purposes which, I agree, is a Commonwealth responsibility.

But to put it another way, it's like having legislation and regulations that recognise registered nurses who work in public hospitals and ignoring them elsewhere in health. I therefore propose the formal recognition of paramedicine as a health workforce should be undertaken by the Government with the removal of unnecessary impediments to practice that date from a bygone era. I have provided a supporting paper, which I have called *The ANZSCO Anomalies*, and I would like to table that. This discusses the need for a review of the Australian and New Zealand Standard Classification of Occupations, or ANZSCO, to ensure the appropriate classification of paramedicine and its inclusion within the health domain as a nationally registered health workforce. This might include roles such as community paramedics or practitioners working in urgent care centres, GP clinics, district hospitals or alongside other health professionals.

The effective deployment of paramedics and their contributions to health will be limited without embedded representation and the input of expertise at a senior policy level. I therefore propose the input of clinical and operational advice through the appointment of an independent chief paramedic officer within the Department of Health, as already exists in Victoria. To optimise the capabilities of NSW Ambulance, enhanced roles are recommended for paramedics employed by the service that would enable innovative models of response likely to safely minimise transport to hospital emergency departments. Examples of new models of care from the UK are provided to supplement pilot studies and other work currently being done within Australia. I wish the Committee well and I will answer any queries to the best of my ability.

The CHAIR: Thank you, Associate Professor Bange. Just to confirm, in regard to the supplementary document, which is headed *Occasional Paper: The ANZSCO Anomalies*—and then there is a subheading—dated August 2022, we have received that and circulated that to members. That will become part of your evidence to this inquiry.

RAY BANGE: Thank you.

The Hon. ROSE JACKSON: I thank both of you for coming along. I'll try to move through a series of questions reasonably quickly just to try to cover a few issues. The first thing is just to establish clearly from both of you that, consistent with the submissions and the comments that you've made, it is your view that the issue of ambulance ramping and bed block in emergency departments is increasing in New South Wales. That is your understanding of what is happening in our hospitals and with our ambulance system right now?

RAY BANGE: If I may answer, yes.

DAVID WATERS: From my perspective, yes, it is increasing. I think you can see from the recent report by the Australian Medical Association—AMA—that it is increasing across all jurisdictions. It is a global issue. But interestingly, and worth noting, New South Wales' response still has the best performance across ambulance services in Australia.

The Hon. ROSE JACKSON: So we recognise it's beyond question that this issue is prevalent and increasing. Do you think that that increase has been predictable? Is that something that we have seen over a period of time is becoming more and more predictable or do you think this is something that has come out of nowhere? I might start with you, Mr Bange. Mr Waters, if you have anything to add, that would be useful too.

RAY BANGE: I would suggest that it is predictable but that the extent or the prevalence of ramping or bed block has been exacerbated by the COVID-19 pandemic. That was not predictable. However, in the long term there needs to be consideration of the workflow. The workflow is a factor that is systemic, and the demand and stress within the system has been increasing at a steady rate.

DAVID WATERS: I would agree to a degree. Transfer-of-care delays have been in existence for many years—in excess of 10 actually. Ambulance services throughout Australia and the world have worked with health services to manage transfer-of-care delays. Certainly in our post-COVID or near post-COVID world, the peak that we saw as a result of COVID and our winter peak hasn't returned back to what we would have expected as normal levels, and we're not seeing any signs that's going to happen any time soon. So I think you're right in your assumption that we will continue to see an increase in transfer-of-care delays due to the current system infrastructure that we have in our health system—

The Hon. ROSE JACKSON: I think there was a comment made [disorder]—I apologise; continue.

DAVID WATERS: I was going to say I think we do have to recognise ambulance services, and their colleagues in ED and health services, have tried many, many different approaches to manage transfer of care. We're continuing to see new initiatives. The good thing about COVID was that it introduced a lot more recognition of the value of virtual care and virtual ED and telehealth and a whole range of other electronic approaches to managing patients. Those benefits continue to be exploited further.

The Hon. ROSE JACKSON: It's good to try to find something good out of COVID, I suppose—some kind of very faint silver lining. There was a comment made by a witness earlier today from the Australasian College for Emergency Medicine that suggested, if you look at least in New South Wales, ambulance ramping is the new normal. Mr Waters, is that consistent with your comment that we just have not seen a decrease after COVID and after seasonal peaks—that this current situation is now situation normal for New South Wales hospitals?

DAVID WATERS: It's jurisdictional, certainly. We have seen this level of transfer-of-care delays in other ambulance services prior to COVID, and it's very well reported. Opening the media on a daily basis, you will see ramping across all Australian States, Territories and, of course, United Kingdom, Canada and the US. The reality is that we're seeing an influx of patients who have delayed treatment—hence the increase of patients presenting to ED—compounded by difficulty in accessing GP practices and difficulty in accessing post-hospital care in the community. We're just seeing an increase in bed block, bed access, in all systems at the moment.

The Hon. ROSE JACKSON: It is just important to establish those underlying facts because, as you say, there has been quite a lot of coverage of these issues in other jurisdictions. But the suggestion has been made that this isn't something that is a problem in New South Wales, that this isn't something that our health system is dealing with. So part of the purpose of this inquiry is actually establishing those underlying facts and that, no, in fact, this problem is certainly an issue in New South Wales as well.

Now that we've got that clear, I want to move on to a question about what that means. What does that mean for the individuals, the patients, who were caught up in this situation? I wondered if either of you had any reflections on the adverse impacts that ambulance ramping and bed block is having on patients. What does that look like? What does it mean when we use terms like "ambulance ramping" or "care delays"? They can sound a bit clinical, in a way. It's important to take the conversation to the patient level and be clear about what sitting on an ambulance trolley for up to 12 hours actually looks like. What does that mean for someone who is seeking care? Professor Bange, I might ask you whether you have any reflections first, and then Mr Waters.

RAY BANGE: I'll be fairly brief. It can be demoralising. It can be mentally distressing. It can, in fact, lead to the deterioration of the patient. I take your point. I don't like the term "ambulance ramping". That totally takes away the issue of the impact on the patient. I tend to talk about "patient stacking" and "patient delay". That's more relevant because of the impact on the patient that is most critical. But let's not forget that it also has a serious impact on both the mental and the physical health and wellbeing of the attending practitioners, the attending paramedics and the attending people within the emergency department, who feel demoralised because they cannot provide the help that they would like to. David?

DAVID WATERS: I would agree with everything Professor Bange has said in that instance. It is important to note that patients spending an extended time on a stretcher is detrimental, certainly, to their health. Paramedics are trained to respond to emergencies, not to long-term care. Caring for a patient on a stretcher requires them to consider things like nutrition, toileting, pressure area care—many, many nursing-related aspects that they wouldn't normally have to consider and they're having to adapt to. I think more importantly, though, those patients are getting a level of care. The patients who are not getting care are the ones that are not receiving an ambulance in our communities because those ambulances are blocked at the hospital.

We know, and many, many ambulance services are now reporting, many hours are lost in regard to ambulances unable to leave a patient and return to the community. In a typical shift, an ambulance crew would see eight to 10 patients often, currently now in many jurisdictions, but it's not necessarily the case in New South Wales to the same degree—they're seeing one or two—so a huge impact. I would like to note that I speak about ambulance service delivery internationally. One of the case studies I hold up as best practice is NSW Ambulance's relationship with its health department in managing transfer-of-care delays. It is an exemplary example of a commitment of senior executives in both the health department and the ambulance service to put the patient at the centre of their care and try to minimise transfer delay in any way they can. As I said, I often hold it up as a best-practice example.

The Hon. ROSE JACKSON: Mr Waters, do you have any New South Wales-based statistics both in terms of the number of patients seen per shift, for example, or the number of hours lost to ramping? Those kind of figures are particularly useful for us. Is there anything that you can provide us in that regard?

DAVID WATERS: I don't have that information to hand. I could take that on notice certainly.

The Hon. ROSE JACKSON: That would be useful.

RAY BANGE: I would also mention that the health information system within the New South Wales Government and health system provides an extraordinary amount of information about issues like that.

The Hon. EMMA HURST: Thank you both for calling in to join us today. Associate Professor Bange, your submission focuses on better mobilisation of the paramedic medicine profession across the health domain. One of your recommendations is that paramedics be given a broader role to deliver out-of-hospital care, including prevention and community-based health management services. Can you talk a little bit more about how you see this working in practice?

RAY BANGE: This can occur in a number of ways. One way, of course, is the ambulance sector itself can provide assistance in a partnership arrangement with clinics and health departments and the like. Another way is that a paramedic can be employed within a clinic or external community service or Aboriginal-controlled health service or similar, and I have given an example of the UK system where they have the alternative reimbursement of allied health and paramedicine. I suggest that those models can be employed or looked at by the Committee. I'd also like to mention that Canada and the US have multiple models of community paramedicine, in most cases being provided by the particular ambulance service, but if you have an expert health practitioner, then I suggest you should try to use them, and that may be in a clinic situation, provided the government system and legislation and regulations allow that to occur.

One of the problems is that the Commonwealth Government in particular does not recognise paramedics for the reimbursement of health care provided by the paramedic for direct billing, so therefore unlike, say, a nurse practitioner, a Medicare item is not provided and the gap—there is no direct billing for the services provided by the paramedic. If the clinic provides or employs a paramedic, then the doctor or the person with the Medicare provider number has to see the patient as well in order to bill and that means there's already a barrier to the employment or deployment of paramedics within clinic situations, and that is why I suggested these impediments need to be examined and to the extent that they are unnecessary, they should be removed so that you can utilise and mobilise that excellent health workforce.

The Hon. EMMA HURST: Will it also then require for the paramedic workforce to expand as well, do you think? If it does need to expand, do you have any rough estimation as to where we would need to expand that workforce to?

RAY BANGE: Paramedics are principally educated and trained to provide emergency care, but that training tends to be expanded more and more into lower acuity areas, and postgraduate courses provide for additional education in areas of diagnosis; in terms of more primary care. In order to fully utilise the paramedic within a clinic-type arrangement, it will be desirable that paramedics undertake micro-credentialing or additional training. But in many cases, that is already in place and they could be mobilised if the opportunities were there.

The Hon. EMMA HURST: I know you mentioned the UK in your submission and you've just now mentioned Canada and the US. Why do you think we're so behind in Australia and is there any sort of understanding that you have as to why governments have been reluctant to do the same thing here?

RAY BANGE: You have to look at the history of paramedicine, and governments have tended to view paramedics through the lens of an ambulance service, and that's good. We have, in Australia, some of the best ambulance services in the world. Let's make no bones about that. They are among the best in the world. They have trained, our paramedics, 30, 40 or more years ago and paramedics were employed by the ambulance sector. However, paramedics now, for the last 25 years, have been trained in universities. People pay for their own

education. They become registered practitioners as a health practitioner under the national scheme and, therefore, they are empowered to work to the extent of their competencies, and that generally is set by the Paramedicine Board of Australia.

The Government, which has at a jurisdictional level tended to look at paramedicine as being within the ambit of the ambulance sector, has, I think, not fully adjusted to the concept of paramedics as an independent registered health workforce. However, if we look at the Commonwealth, we have this State-Commonwealth divide for funding and for legislation as well, and at the Commonwealth level we have very few, if any—I've met none—working for the Commonwealth Government health department who are paramedics. Most of the positions within the Commonwealth health hierarchy, within the advisory committees, within the systems that would examine legislation and regulations are occupied by nurses or medical practitioners, and that's understandable. It is also one of the reasons why at the Commonwealth level and at the local jurisdictional level, we need a Chief Paramedic Officer who can bridge the gap between what was and what should be.

Ms CATE FAEHRMANN: Thank you, Professor Bange and Mr Waters. That is all very interesting. I just wanted to keep going on what you were just talking about, Professor Bange, in relation to the Chief Paramedic Officer, which has been a recommendation from other witnesses as well. Would you care to explain how the appointment of a Chief Paramedic Officer in Victoria has led to better outcomes in that State? And possibly, Mr Waters, if you care to respond to this as well, but I'll go to you first, Professor Bange.

RAY BANGE: I think the first thing is that it means that paramedicine is considered when it comes to issues related to workforce. The Chief Paramedic Officer in that State has a senior role, one of the top four executives in the lead leadership team, and during discussions on how responses will be made to things like COVID, to vaccination, to mental health and other areas, that CPO has been able to put a point of view which really only comes from a lived experience. The position also is independent from the ambulance service. The ambulance service has a very important role in looking after its principal responsibilities, but the Chief Paramedic Officer stands alone or stands independently and is able to provide an input that takes into account not only the public ambulance service but also the private paramedics who are working out there in the field. What you do is you get an input which is more holistic and is able to take account of the benefits and the contributions of a firsthand knowledge of what paramedics can do.

Ms CATE FAEHRMANN: Mr Waters, did you have anything to add to that?

DAVID WATERS: Certainly. I absolutely support the concept of chief paramedics. I think it's very important to have paramedicine at the table for these very important discussions regarding health and emergency management from a health perspective. My view, though, in regard to your current inquiry is that the most important thing to consider is that ambulance services transport somewhere between 25 per cent and 33 per cent of all ED admissions to hospital. That is a significant amount of patients. We have the ability to work together to reduce that amount of patients presenting to the ED.

The New South Wales example of the VCCC, the Virtual Clinical Care Centre, is a great example of how we can manage patient flow, provide solutions for patients in their homes without them having to be transported or provide some forms of referral service. We're seeing a significant—in fact, a massive—investment in the equivalent of the VCCC in other jurisdictions to manage patient flow to ED, with a lot of success. I think, in the short term, it definitely will contribute to reducing transfer-of-care delays. In the longer term, planning across the whole of Health with input from the appropriate level of paramedicine and paramedics, as in the form of a chief paramedic at those key decision-making tables, will definitely impact on the quality of patient care, workforce planning and a whole range of other contributing factors to improving patient safety.

Ms CATE FAEHRMANN: Quite a few submissions to this inquiry have raised the issue of a lack of mental health beds, particularly, and also a lack of care within the aged-care facilities, which places an additional strain on beds. Beds are occupied by people waiting for NDIS placements. What are your thoughts on that? Let's start with mental health: Does that seem to be a big contributor to the access block that is at the core of this inquiry, in your experience, Mr Waters?

DAVID WATERS: Certainly. Anecdotally, there is a lot of support that says our mental health patients are not receiving timely care in their communities. It's very difficult for them to access any form of mental health care out of traditional office hours. The 000 system is literally the ambulance at the bottom of the cliff, and they revert to that. Although our paramedic workforce have some mental health training, they are not mental health experts in their own right. They need to collaborate with mental health teams and on occasion with police.

What we are finding in a number of jurisdictions is that a dedicated paramedic, mental health nurse, police response reduces the number of transfers to ED significantly—although that is still a sticking plaster to the much broader issue of a lack of mental health resources and access to mental health services, generally speaking,

for our community. The same can be said for aged care: We know that in the residential aged care setting, the ability for higher level clinical decision-making out of hours is slim. The care staff who are on duty refer to the ambulance service as, again, the only option left open to them. For many of those patients, they don't require to go to ED; they need a clinical intervention in their place of residence, and that is just not available to them in the current situation.

RAY BANGE: If I could just add to David's comments, I absolutely agree. Mental health presentations are significant for the ambulance sector. It's also perhaps less understood or recognised that falls are a key input area, particularly in the aged-care area. You find the response to falls taking somewhere between 25 per cent to 35 per cent. I'd have to check the latest trauma registries to confirm that but, particularly in the older patients, falls are a significant load on the system. My final comment on this aspect is that of hospital flow and the 24/7 nature of presentations, and the fact that hospitals tend to operate or have operated on a nine-to-five basis five days a week, but the load on the hospital may occur at any time. Looking at the flow through a hospital, the ability to have an exit from the hospital will determine what beds are available. Too often it's found that there is nowhere for the patient to go—no mental facilities, no aged-care facilities. The care of the exit patient is critical to the ability to have beds available and cascades back through the system, right through to the emergency department.

The CHAIR: Gentlemen, that brings us to the conclusion of this session. On behalf of the Committee, I thank you both very much for your participation. You bring to the table a great deal of experience, knowledge and information, a fair bit of which you've been able to share with us today. I'm sure it will inform us most helpfully in the deliberations to prepare our report and its recommendations.

(The witnesses withdrew.)

(Luncheon adjournment)

Dr PRAMOD CHANDRU, Emergency Medicine Staff Specialist, affirmed and examined

Dr JAMES TADROS, Emergency Medicine Staff Specialist, affirmed and examined

Dr SETTHY UNG, District Chair, South Western Sydney Local Health District Medical Staff Executive Council, affirmed and examined

The CHAIR: Good afternoon and welcome back, everyone, to our sessions this afternoon. We're very fortunate to have three very experienced emergency medicine staff specialists with us, along with the District Chair of South Western Sydney Local Health District Medical Staff Executive Council. Thank you all very much for making yourselves available. I can't imagine how busy you are as experienced clinicians out there in the field, so you've obviously had to carve out time not just to make your submissions, which are very helpful, but also to make the time and we do appreciate you doing that for us.

Just to confirm, I am grateful for, as I said, the effort that has gone into your submissions. Dr Chandru and Dr Tadros, your submission has been put before us, been processed and now stands as submission number 21 to the inquiry. It has been uploaded to the inquiry's webpage and stands as evidence to the inquiry. Dr Ung, your submission for and on behalf of the Medical Staff Executive Council has been received and processed and stands as submission number 24 to the inquiry and has equally been uploaded to the webpage on the Parliament's website and stands also as evidence to the inquiry. What I'd like to do if you're agreeable is invite an opening statement. Try and keep it relatively brief. That will maximise the opportunity for the back-and-forth questioning. You can take as read the content of the submissions, so there's no need to read from the submissions per se. We have representatives on this Committee from the Opposition, crossbench and Government. If you're agreeable, what we would like to do is, after the opening statements, share the questions between ourselves. That will help elucidate what's in your submissions but also draw on some of the other points that no doubt you'll make in your opening statements. Are you okay with the procedure that way?

SETTHY UNG: Yes.

JAMES TADROS: Yes.

PRAMOD CHANDRU: Yes.

The CHAIR: We'll commence.

PRAMOD CHANDRU: I'd like to thank the Committee for giving me the opportunity to speak. My name is Pramod Chandru. I will be speaking as an individual. I am an emergency staff specialist working and trained from medical school all the way to my consultant level practice at Westmead and Nepean hospitals. Dr Tadros will do a submission on behalf of me.

The CHAIR: On behalf of the two of you? That's fine. That will be nice, thank you.

JAMES TADROS: My name is James Tadros. I did all my training across western Sydney from university medical school onwards. I currently work as a staff specialist at Nepean Hospital and I also do some work across other districts at Concord and Ryde. I am here representing myself as an individual, as an emergency specialist. This is something I've prepared. Dear Committee members, we would like to thank you for the time and opportunity for us to express and articulate some of the frustrations that we experience working in the emergency departments of New South Wales and, more specifically, in western Sydney. It was not our goal, when we started out our training in medical school, to find ourselves in circumstances that see us failing the needs of our patients on a daily basis, and consistently lowering the expectations we have of ourselves, the system we work in and the demands that we can place on it. But this is the truth of our current working environment. We are not good healthcare providers, and it is not because we are not trained and educated but because we work in an environment that we don't see as conducive to good medical care.

Having trained in western Sydney and now supporting trainees in western Sydney, the effect on staff is extremely difficult to ignore. We are taught as doctors to introduce ourselves first, but now we find ourselves also spending the first few minutes of our patient interactions apologising profusely for delays to diagnosis, delays to treatment, absence of beds and absence of privacy, all of which most patients tolerate admirably. These people we serve bear the brunt of our failing system with remarkable good grace and kindness. But the truth of the matter is that our healthcare system, though great in many ways, is not equitable, equal or fair. We practise good medicine, we save lives and we provide whatever treatment we do in spite of the system rather than because of it.

Dr Chandru and I often text each other our experiences at work, sometimes amid a shift in a quick break for water or food. I suppose this is a coping mechanism for the system that we have become a bit disillusioned with. I would like to read a transcript out of one of those experiences that I sent to Dr Chandru earlier this year,

where I was expressing some frustration, but I've altered some of it just to make it easier to understand and to remove some of the medical jargon.

The CHAIR: I'm sure you'll take this into consideration: If need be, deidentify any individual.

JAMES TADROS: Yes. I wouldn't generally do that.

The CHAIR: No, I appreciate that.

JAMES TADROS: I will start off with what I've said: "I've spent hours trying to sort out an 88-year-old lady in kidney failure who has been waiting six hours. I had to go out to the waiting room to pick her up in a wheelchair. I found her laying down across three chairs, and some bystanders were helping her daughter to slowly move her around because she was so week. This is basically Third World. They just keep prioritising the ambulance offloads who aren't the sickest. It took me 20 minutes just to get her into a wheelchair, then wheel her around to find a space to see her." Dr Chandru replies, "What a use of time." I then reply, "The nurses just can't start anything for this woman while she's out there. They cannot give any slow intravenous fluids, but she is 88, so a fluid bolus will just put her into pulmonary edema and might kill her. Maybe that will get her a bed. I just wrote up 500 mils to try and do something for her."

I continued later on in the evening. This was four hours later, 12 hours after the patient first presented and six hours after she was first seen. It was five hours after I ordered her initial CT scan. I said, "Remember the 88-year-old? Her abdomen is riddled with metastatic cancer of unknown primary. Twelve hours later, she finally got to a bed in time for me to tell me that she was probably going to imminently die from this. The worst part is, her and her daughter have been so nice the whole time, despite our rubbish care. She still hasn't had the fluids." Dr Chandru replies, "God, that makes me feel worse."

We do not argue that we are an authority in the field, but in our submission we wish to highlight causes of access block and ambulance ramping that we have identified, their effects on patients and staff, and strategies for improvement we would like to put forward to the Committee. Dr Chandru and I sit before the Committee today to advocate for our patients, our staff, our students and an apparently universal healthcare system which we believe has failed to keep up with the modern demands. Thank you.

The CHAIR: Thank you both, doctors, for that joint opening statement. It's very frank and to the point and I'm sure there will be some questions following the second opening statement. Dr Ung, would you like to make an opening statement?

SETTHY UNG: Yes. Thank you Chair and thank you Committee members for the invitation to come before you today to represent the 1,500 senior medical officers working in the public hospitals of south-west Sydney. We would like to have acknowledged the tremendous efforts put in each and every day by our colleagues, ambulance officers, emergency doctors, emergency nurses and allied health colleagues, doing their utmost to preserve safety and quality care at the front door of our system.

We strongly believe the undue pressures and stress they are under due to access block and ambulance ramping can be offset by providing a combination of adequate hospital inpatient capacity to be able to consistently receive the flow of acute admissions, and sufficient outpatient capacity to facilitate them returning home, as well as providing specialist services for chronic and complex patients to ensure their disease processes are optimally maintained in the community, to avoid them needing to access hospital care acutely as much as possible. In particular, we wish to highlight to the Committee the challenges faced by patients and families living in difficult socio-economic circumstances in western Sydney and those coming from a culturally and linguistically diverse background, needing to access emergency departments for non-urgent but necessary care due to the lack of access to services in the community. Thank you.

The CHAIR: Thank you, Doctor. We will commence with the questions. As I said, we will share it around between the respective groups represented here at the table. We'll commence with the Opposition, the Hon. Rose Jackson.

The Hon. ROSE JACKSON: Thank you, Chair. Thank you, doctors, for taking time to come and talk to us. It's incredibly important to hear your perspective on this issue. I wanted to start just by establishing the nature of the problem because there has been some suggestion, in representations from the Minister to this Committee previously, in public commentary, that access block and ambulance ramping are not problems in New South Wales, that those are problems that other jurisdictions are dealing with but that here in New South Wales it's not really something that we're experiencing. That's not reflected in your submissions. That's not your experience, is it.

PRAMOD CHANDRU: Are you happy if I start?

The Hon. ROSE JACKSON: I'll just throw the questions generally. If I have a specific one, I will put it specifically. But I'm just really welcoming all of your feedback.

PRAMOD CHANDRU: Perfect. I think the easiest way for me to contextualise the response to your question is that when we are taught how to practise emergency medicine by the college in their routine guidelines, there are standards of care by which we abide. None of that really factors in to account the system, with the assumption that the system is functional. I can remember a time when I started practising emergency medicine as a junior doctor, which for all intents and purposes was not that long ago. I started 2015 as a junior doctor, as a junior emergency trainee. Access block and ambulance ramping was an issue, were terms that I had heard of but were exceptions to the rule rather than the rule itself. I cannot remember a time in the recent past—I would extend that to anywhere between five to seven years—where I have practised in an emergency department with appropriate access and flow. I honestly also am not sure that I would know how to practise emergency medicine with access and flow now, because I've had to adapt my methods of care and routine practice to cater for a system that is not working.

The Hon. ROSE JACKSON: Would you agree with the statement that access block, delays in treatment in our hospitals—that's the new normal. That's normal now, for those delays to be there, for patient care to be compromised because of those delays. That's situation normal.

PRAMOD CHANDRU: In my experience in the hospitals I work in, yes, that is the norm.

SETTHY UNG: Unfortunately, Dr Chandru talks about not normalisation of access block and ramping but a numbing. The frontline staff have become completely numb to it and are not condoning it or accepting it but have learnt to adapt, to live on the knife's edge. The effect of this on the frontline staff—doctors, nurses, allied health—doesn't really get displayed until they completely burn out and they leave the workforce.

The Hon. ROSE JACKSON: Dr Tadros, I think you said in your opening statement that you feel as though you're failing patients daily. What kind of impact does that have on you as a clinician and on colleagues who feel, every single day, every single shift, that they can't provide the level of care that they want to provide?

JAMES TADROS: Yes. It's tough. I think it's important to understand that not all places are equal. Unfortunately, you see the hospitals in western Sydney do bear the brunt of this. I think that's evidenced in the data that has been presented several times and, I'm sure, everyone has been across. I think it's multi-factorial as well in terms of the way it affects staff. I think, in terms of our trainees, we see a situation in which—we have our trainees coming towards the end of their training, and they have to sit exams. Those exams, like Dr Chandru alluded to, are based on a standard of care that we're expected to deliver. You're expected to answer the questions in a correct manner that takes into account what the hospital situation should be like. A lot of our trainees who have done all their training in western Sydney recently do not know how to answer those questions, because they have not encountered situations where they have access to the resources available.

A common example is that the college of emergency medicine frequently asks about situations where there's a surge or there's a disaster that needs to be dealt with. That question is answered on the basis of a hospital having a normal amount of occupancy, which we see as somewhere just above 80 per cent or around 80 per cent. Most hospitals, especially within western Sydney, are operating at 100 or close to 100 or even over 100 per cent capacity. So those trainees actually don't know how to even approach those questions. They don't know that they can decant patients to somewhere else, because they're used to operating in a situation which is always a disaster. There have been situations where people have been confused by the question because the question alludes to a disaster and they're expected to identify that but that for them is what they're doing every single day.

I think that takes its toll—but also the fact that we are seeing high rates of burnout. We are seeing trainees who leave the workforce and go do something else. We are seeing people who just struggle with every shift. I think it's a very unfortunate thing to see, especially for something that we obviously have a passion for and we've chosen to do and we've chosen to invest years and years of our lives into training towards. So it is very disheartening but also has marked effects on training and will for years to come.

The Hon. ROSE JACKSON: One of the challenges here in a way is, as you say, trying to decipher what can often be quite clinical language into concepts that are easy to understand. In your submission, you talked about patients waiting so long after being triaged that their clinical acuity had transcended their initial triage category. I'm translating that from doctor to politician to mean that patients are coming in, presenting with an illness or a disease or an issue and that, as a result of the delay alone, that situation has deteriorated. Is that right? Can you explain what that means in a way that we might be able to understand as lay people?

PRAMOD CHANDRU: Of course. I think where it starts from is the Australian triage scale or the ATS, which is what's used across all emergency departments in Australia in order to categorise the urgency of treatment required for a patient, numbered from one through to five. As part of the ATS, there's an understanding that

patients who have a higher number category can wait longer to be seen. Those numbers vary. I guess one of the challenges of emergency medicine in the context of access block and delays to treatment is, for example, you have a category two patient who could vary in their presentation or the reason they've come to the ED but, in general, requires medical review and assessment within 10 minutes of triage.

The Hon. ROSE JACKSON: Help me out here. Is that a car crash? Is that falling off a ladder?

PRAMOD CHANDRU: Someone with chest pain would be a classical example. That patient requires assessment and treatment initiation within 10 minutes, as per standard operating procedures in all EDs. Where it becomes challenging as a clinician is you might walk into a department and there might be someone who has a higher category—for example, a category three or a category four. That might be a patient with abdominal pain, for example. A category three patient should be reviewed within 30 minutes. But that category three patient has been waiting 3½ hours.

Now it becomes very difficult to know if I should go see the chest pain within 10 minutes or if that patient who has been a category three, who has been deemed to be clinically urgent enough to be reviewed in 30 minutes is, in theory, a lower number now. That's what I mean when I say they've transcended their category. A category three that's been waiting for three hours may no longer be a category three and may actually be a category two. There are processes within the system to re-triage patients, but my triage nursing staff are overwhelmed with new patients. It's very difficult for them to associate and do the clinical reviews required. So things become very challenging. That's, I think, what I was trying to articulate by that statement. Does that make sense?

The Hon. ROSE JACKSON: It does. Let's talk about the consequences of that. Do you see people who you believe are dying unnecessarily because they're not receiving the care that they need to receive—someone who has abdominal pain, that's waiting far too long, or chest pain that's waiting far too long?

PRAMOD CHANDRU: Yes.

JAMES TADROS: Yes is the answer to your question, frankly. You do see patients who deteriorate while waiting to be seen. You see patients who deteriorate while waiting treatment. There are situations that are very frustrating, where you have made the effort to see a patient in a corridor, with absolutely no privacy, in a loud situation, sitting on a plastic chair. You have identified their issues. You have made a plan for treatment, but you cannot initiate that treatment due to a lack of treatment space. You can watch them deteriorate in front of your eyes just because you don't have any access to treatment for them.

The Hon. ROSE JACKSON: You've seen patients die as a consequence of those delays, those—

SETTHY UNG: Fortunately, I have to say that they do occur, but they're not very frequent. Let's be honest here. They're not very frequent. But the bigger impact is the delay in treatment. Prior to cardiac arrest, if you get a disease process and it is allowed to go past a certain point, then it significantly prolongs their length of stay in hospital. Then they contribute to the access blockage.

The Hon. ROSE JACKSON: Yes. I can see that—vicious cycle.

PRAMOD CHANDRU: Furthermore, death and adverse outcomes from a mortality point of view are bad, yes, of course. But when you have an eight-year-old child who has a broken elbow and they have been waiting three hours to get some pain relief, that is a travesty in and of itself, independent of whether or not the outcome is bad for that patient. Triage categories are assigned based on, obviously, the severity of illness but also the need for acute treatment. So sometimes the delay to that treatment can be just as bad as, you know, an adverse outcome for the patient—both of which, I think from a patient point of view, are unacceptable. So, yes, the deaths are bad and I agree they don't occur commonly, but they do occur. Adverse outcomes occur frequently. But delays to treatment and unnecessary patient suffering occur very commonly because of the delays that occur from this.

SETTHY UNG: I'd also like to mention, on behalf of the staff working in emergency departments now in New South Wales, that what goes under the radar are the near misses. The patients who get salvaged—you know, they've been waiting for a long time then they finally get picked up and there's a quick flurry of activity. Their lives are saved but the staff are under constant stress trying to patrol their department, trying to pick out these patients from the wait rooms because they're not in a bed initially to be assessed appropriately.

The Hon. EMMA HURST: Thank you all for coming in today and providing evidence. Dr Ung, you've already covered this a little bit but I just want to sort of flesh it out a bit more. You noted in your submission that a lot of patients are needing to stay longer in emergency departments, sometimes for days, and that that longer length of stay is the bigger problem rather than the sheer volume of patients coming into the emergency department. Can you give a little bit more information about why they're needing to stay longer in the ED and what's contributing to that?

SETTHY UNG: Yes. The patients will get assessed, get diagnosed and an initial management plan is put together. But, unfortunately, the emergency department doesn't have the specialty resources and allied health—and I'll use stroke as an example; everyone's familiar with stroke. If you've had a stroke, you need to access a stroke unit where you can get the allied health services to rehabilitate. Spending a day or more inside an emergency department where it doesn't have the right environment or resources to address that, then it prolongs the recovery and sometimes it's detrimental to recovery. That's because the stroke wards are full already and not just full but the back end of it, where the stroke acutely treated patients are waiting for a rehabilitation bed, if those rehabilitation beds are consumed already, then there's that back flow. Then the overall patient journey or the length of stay in hospital gets drawn out.

The Hon. EMMA HURST: You also explain in your submission that the ambulance ramping problem is so grave, particularly after hours, that patients that have been driven to hospital are given lower priority, purely because of the need to actually just free up ambulances to get them back on the road. Is this fairly standard, or is it specific to South West Sydney LHD?

SETTHY UNG: I can only speak for south-west Sydney. I think the gentlemen can speak for the rest of western Sydney, but I'm fairly certain that it is across the board in that they're not actively given lower priority, but the demand—and we support our hospital executives getting the ambulances back out there. If we need to offload an ambulance to be able to respond appropriately in the community, then everyone will lean towards that patient waiting, who has come appropriately by private transport, just to wait a bit longer, a bit longer. But sometimes the bit longer ends up being hours longer.

The Hon. EMMA HURST: Do the other doctors have anything to contribute to that one as well?

PRAMOD CHANDRU: I agree. I think it's a strategy that has been employed at the hospitals that I work in, both of them, and I agree. It's one of those things where it's incredibly frustrating to see people, who sometimes have even waited for an ambulance and either realise that it's going to be too long and come in out of sheer concern, and then not being able to get them into an appropriate treatment space. I am not of the opinion that one process is more important than the other. It's just a frustrating clash of unstoppable forces that end up culminating in poor patient care, really.

JAMES TADROS: I mean, there is just a situation where there are some patients who arrive by ambulance and they may have a lower clinical urgency but, due to other issues, they need to be offloaded to a bed, for example. A classic example is a lot of our patients who come from aged-care facilities. They're not people who an ambulance can bring in and it's just, you know, get them to sit in a chair or they can walk around. They need to be offloaded to a bed. Unfortunately, that then takes up an acute care bed, and that acute care bed can't be used for someone who maybe have brought themselves in. And I think we do—it's frustrating, but we've just come to have to figure out some sort of medium because we're trying to work in a system that doesn't really work. So we're trying to get those ambulances back out there because we know that that will just lead to further delays in treatment for people who need it.

The Hon. EMMA HURST: Yes. I just want to get your thoughts as well about the impact of all of this and the pressure on emergency doctors and how it's impacting junior doctors and other medical care staff. I assume it's affecting training, particularly, for junior doctors and their experience as well. I just want to get your thoughts around what's happening in that space because of these problems.

SETTHY UNG: I am a trainer of junior doctors and I'm very proud of these two gentlemen next to me, who came through our medical school.

The CHAIR: Hear, hear!

The Hon. ROSE JACKSON: Hear, hear!

SETTHY UNG: I think, for me, having trained doctors over the years in emergency medicine, it has really accelerated their burnout. We don't expect doctors to burn out in their mid-forties. So much time and energy is spent to train them, just to see them burn out well before their expected retirement dates is tragic. It's really, really tragic and, more importantly, we can't backfill them, either. As soon as they burn out, there is a very small pool of junior medical staff who can then be trained up to become a senior medical officer.

Ms CATE FAEHRMANN: I just want to pick up on that, actually, if I may, particularly with Dr Chandru and Dr Tadros, in relation to the mental health impacts that the situation in our hospitals—you've called them Third World and a disaster. What's the mental health impact if you want to talk about your colleagues or yourselves? I'm sure we've heard that it is severe. As you've said, doctors are quitting, and worse.

PRAMOD CHANDRU: Look, I preface this with saying that I love what I do and I enjoy going to work every day, but part of my role as a senior staff specialist is to provide education and training. It's an in-built role.

Any senior doctor will say it's part of their job, but it's an area of interest of mine and so I've had close relationships with trainees ever since I was a trainee myself. There's no doubt that rates of burnout and disillusionment with the system—all of these problems—whilst being exacerbated by COVID and the problems that occurred because of it, were on a trajectory that was leading to this point anyway prior to COVID-19.

In the years prior to COVID-19 the access block was accelerating remarkably quickly and adaptations and concessions were being made around patient care. But obviously COVID—as it did with so many other things in our country as a whole—brought out inequities within systems and I think that brought those problems to the fore, which accelerated burnout. We're in a state now where junior medical workforce recruitment for ED training is at its worst I've ever seen, particularly in our area health services, and so again that speaks to the problem that Dr Ung was implying—that backfilling these positions when senior medical staff retire, or when they leave the profession altogether, is almost impossible.

JAMES TADROS: Yes. I tend to agree and I think that one of the factors that I'm proud of but that also is very unfortunate is the fact that a lot of staff are being held up by their colleagues. I think that there would be a lot of people out there, a lot of staff who you would come across within the health system, especially within emergency departments, who would say that they probably wouldn't cope with the job without their colleagues there to support them. Although it is excellent to see that that's happening, I don't think it should be that way and I don't think the onus should be on other staff around them to basically prop them up and hold them up and help them through.

Ms CATE FAEHRMANN: There's no doubt from the evidence already this morning and from both of your very good submissions that there is a crisis. Clearly you would have gone to the hospital executive or the LHD to let them know what's going on in the hospitals to offer solutions. What has been their response? Are you finding that the LHD is listening to your requests for help? We're really keen to find out whether they're listening and what they're doing about it.

SETTHY UNG: In my role as the district medical staff council chair, I would have regular interaction with our executive. I have to say, we do work very well and closely together. But the problem is beyond them. We talk about the constant need to catch up in resourcing for south-western Sydney, for example. I'm sure western Sydney is the same. We both lobby separately to resource the rapidly growing population in south-west Sydney. We were here talking about this a couple of years ago. We're constantly on the back foot—constantly—and always playing catch-up. Never have we got to the point where we think, "Okay, now we're resourced for our population. Let's make it leaner, let's maximise it." We are still on the back foot.

JAMES TADROS: I think there's only so much give you can have in a system that's at 100 per cent occupancy. I think there are lots of you can call them solutions but probably not so much solutions that people have put forward over the years that have been implemented. That's probably the only thing that's got us through up until this point. But there's only so much give in the system, and I think that's probably been maximised up until this point.

Ms CATE FAEHRMANN: In terms of your situation, you're saying that it's a system-wide situation. When you're saying that the beds are operating at 100 per cent or above 100 per cent capacity, what does above 100 per cent capacity mean? Because 100 per cent capacity is every bed full, right? You're talking in corridors and stuff, potentially?

JAMES TADROS: A patient in the waiting room awaiting a bed for a day who's been identified as someone who needs acute care but who is still sitting there. I see that as above 100 per cent. That's not a treatment space; that's a patient who's—

Ms CATE FAEHRMANN: Should have a bed and doesn't have one.

JAMES TADROS: Yes.

PRAMOD CHANDRU: Normally we would start our shifts with anywhere from 30 to 40 patients in a situation like that, and maybe 10 of those not in treatment spaces—so sitting in inappropriate treatment spaces: chairs or in the waiting room.

Ms CATE FAEHRMANN: You had your mouth away from the microphone for a minute.

PRAMOD CHANDRU: Sorry.

Ms CATE FAEHRMANN: Anywhere between how many patients?

PRAMOD CHANDRU: In terms of admitted patients to an ED, on average we would have anywhere from 30 to 40 admissions in an ED at the beginning of my shift. Out of those 30 to 40 patients, anywhere from 10 to 15 of them would be in inappropriate treatment spaces and so would be counted as over census. That's what

we would mean by operating at more than 100 per cent. So you might have an admitted patient in a chair or in the waiting room waiting for a bed.

SETTHY UNG: Also, when we're talking about 100 per cent occupancy or more, we're talking about staffed beds. There have been a lot of capital works and there are empty wards and empty spaces. They're not counted in the denominator. They are not staff beds. They're physically there. They're built and ready to be staffed. We just need the staffing and then they can be commissioned as beds to access.

Ms CATE FAEHRMANN: They've been officially opened by the Minister, I'm assuming, these shiny wards?

The Hon. WES FANG: Your time has expired, as you pointed out previously.

The CHAIR: The Hon. Wes Fang.

The Hon. WES FANG: On that issue, and I note that Ms Faehrmann was getting quite excited over there—

Ms CATE FAEHRMANN: So does the Minister.

The Hon. WES FANG: Order!

The CHAIR: You're not the Chair.

The Hon. WES FANG: Sorry, I have taken your job. My apologies.

The CHAIR: Let's proceed with patience. Let's get on with it.

The Hon. WES FANG: On that issue, we know that when we build a hospital we are building it for decades and generations to come. If we were to build a hospital right now that has every single bed opened, that really wouldn't allow us to have much capacity into the future, would it?

SETTHY UNG: Of course, based on population data at the time of design.

The Hon. WES FANG: So having a hospital that has extra treatment facilities that can be expanded into the future would seem like a more sensible approach to hospital design, would it not?

SETTHY UNG: But sometimes population predictions change, and the opportunity to revisit population changes and requirements demand do occur. I do concede they do occur; however, there is a lag. When the population shifts or rapidly expands, like in south-west Sydney, and there's the 12-monthly budget cycle that says, "Yes, we recognise that. Let's resource it a bit more," there is a lag to staff these beds, to recruit the staff to fill them. Unfortunately, the area that bears the brunt of this lag is the emergency department.

JAMES TADROS: I want to add to that. Often that planning is already on the back foot. Using the example of starting everything, it would be the equivalent of you ordering a burger for lunch, me cutting the burger in half, giving you half and telling you that you need to grow into eating more of the burger when, in fact, it doesn't make you any less hungry at the end of the day because at the time you needed that entire hospital. If you build a hospital with, let's say, 500 beds, and that is the requirement at the time, only opening 400 beds and saying that the rest is for future expansion while it's the need now doesn't mean it's any less needed. It just means that it's not staffed at the time.

The Hon. WES FANG: But that's probably not really the right analogy, is it? When we're talking about what we're doing here, what we're saying is that you've ordered the burger, we're going to give you a burger and a salad and you put the salad in the fridge and have it for afternoon tea. That's really the analogy here. What we're doing is we're building what's required now but then we're also adding extra so that in the future when you're hungry again you've then got that opportunity. That's the analogy that we should really be using, is it not?

JAMES TADROS: I'm saying that's what we should be using but what you've provided is actually only half the burger. What's been provided is not adequate for the needs right now. What's provided is well below the needs right now. So it's well below the requirements that are already required.

The Hon. WES FANG: Let's come to that. Did you have the opportunity to watch some of the earlier testimony from witnesses by any chance?

JAMES TADROS: Only part of it.

PRAMOD CHANDRU: I was able to catch a little but I was at work until—

The Hon. WES FANG: I understand that. It's probably a bit dry sometimes. I love tuning in, but not everyone does. That's okay. I assume, as emergency physicians, you're all members of the College for Emergency Medicine. Is that correct?

SETTHY UNG: Correct.

JAMES TADROS: Yes.

The Hon. WES FANG: Dr Clare Skinner appeared earlier with Mr James Gray, who is policy within the organisation. They provided us some testimony that was, in effect, that the ambulance ramping issues that we have in New South Wales aren't unique to New South Wales. In fact, they are prevalent all over the world. The other bit of the testimony that I found very interesting was that they said that New South Wales was probably doing it the best out of all the States and we were doing a lot of things in this space that were a lot better than other States. Have you worked in other States? Have you got some experience of what's happening in other States in this area?

SETTHY UNG: Regardless of that, that's no solace for the patient sitting in the waiting room waiting for a whole day for an inpatient bed, though.

The Hon. WES FANG: I accept that. I think all of us here in this room would have a great deal of empathy for those patients who are in that circumstance. But the question that I asked was have you got experience of what's happening in other States? Given that this isn't a unique circumstance in New South Wales, and given that this is happening across the country—in fact, we heard that in places like Canada it's a lot worse than what we've got here. What I'm asking—

SETTHY UNG: Just because it's a lot worse doesn't mean—

The Hon. WES FANG: I haven't finished my question yet.

SETTHY UNG: Sure.

The Hon. WES FANG: Have you got experience of working in other places? Have you seen what is happening elsewhere? If you know of any jurisdictions that have a better system than what we have in place at the moment, can you provide some of those examples so that we can provide that part of the evidence in the report?

The CHAIR: Before you answer the question, I understand that it was a rather lengthy question with some component parts. I'm not trying to cut you off, but, in fairness to the witnesses, they come with what I would probably describe as intimate, on-the-ground work experience. That's their role. In terms of inviting them to answer questions to do with comparative analysis, with the greatest respect, that may be beyond their remit and either they can't answer or need to take it on notice, in fairness to the witnesses.

The Hon. WES FANG: I'm actually after that real-world experience.

SETTHY UNG: I want to partially answer that. Number one, myself, I haven't worked in other States. I have worked in developing countries in South-East Asia, which don't have the privilege of having an ambulance system at all. But I'm not going to compare apples and oranges here. On behalf of the organisation—the group that I'm representing—I want the Committee to consider solutions outside of the emergency department and ambulance systems themselves and look at the inpatient hospital services capacity and particularly the topic that no-one seems to want to talk about, which is chronic and complex care. There are all these patients with chronic conditions and if they had better care—and that's something to share with the Commonwealth; better care out in the community—they would destabilise less often, need to come to hospital less often, need to be admitted less often and not contribute to the access block issue.

The Hon. WES FANG: I understand that aspect of it. Obviously, there is always the concern that the ED has become the default setting for patients who are seeking treatment when perhaps they are more appropriately seen outside of the system, through allied health or GPs or the like. I understand that's one of the solutions, but in the circumstance that we have in New South Wales—what your college described as one of the better systems—can you identify some of the areas that are working elsewhere that you might have read about or that you have seen in operation that we can look to actually implement here? As we said earlier today, if there was an easy fix, it would have been done already. They are all going to be complex solutions to this problem. Can you perhaps provide some insights as to where we can start with those complex solutions?

JAMES TADROS: I think first we need to highlight the fact that the care given across the State and the issues across the State are not equal. There are hospitals—especially the hospitals we work at and the reason we are here to advocate—that we feel are definitely lagging behind other health districts in terms of access to resources and access to medical care. They are further compounded by the fact that our patients cannot afford to

pay large out-of-pocket expenses for outpatient appointments and not only that but subsequently have reduced access to all those appointments and things. I think first, before asking the question what are people doing interstate or internationally, we need to ask why are people getting different access to medical care depending on where they live across our State. I think when we answer that question initially, then we can further think how can we first make it equitable here before looking abroad.

The Hon. WES FANG: Let's go to that point, then. When you say that the local area health networks that you work in have less equitable access, can you provide some idea as to how other jurisdictions around the State might have better access? I'll speak plainly. I'm from Wagga and I'm a Nat. We have a regional centre and I think we have pretty reasonable access to health care there. I would expect western Sydney would have better access to services than perhaps we do in Wagga. I think we are lucky in Wagga with the access that we have.

PRAMOD CHANDRU: I think you are talking about two very different patient populations there. I think it's difficult to characterise as a single sentence as to what makes our patients vulnerable because everyone's individual circumstances are very different. But when I'm talking about a lack of resources, it's on both sides of the equation: There's not enough resources but there's also an overwhelmingly large number of people who need access to those resources. Even boiling it down to something as simple as if I send someone home and I say, "Could you please see your GP in a day or two to get some follow-up for this particular reason you have come to the ED," and they tell me, "Well, it's a two-week wait to see my GP," what am I supposed to do with that information? It's a reflection of an imbalance in the system.

Whilst I'm not aware of systems in Wagga and how those things work, I can advocate for the patients who I look after, who bring these problems to me every day, the patients who know that there are alternative means and routes to seek health care but none of them are available to them. I think this speaks to the part of our submission where, fundamentally, the friction lies in that you've got a 24/7 health system in the ED and you are trying to interact with what is primarily a nine to five Monday to Friday system. To think that those two systems are going to work in such a way that people don't fall through the gaps is an illusion.

Trying to increase the overlap in the Venn diagram between the interaction between those two systems is the way forward. That's going to look very different in different health settings but, if I was to boil it down for you about what you should be looking for in the solutions that you are looking to implement, fundamentally, it's a policy issue. That might be increasing access to chronic care if a health district identifies that as an area to work for or it might be increasing access to mental health services. As a person who works in toxicology and works in my emergency departments, I know that is a huge issue in the two EDs that I work in.

The Hon. WES FANG: As I said, I don't imagine that there is any simple fix to any of these. When we say distilling it down, there probably isn't an opportunity to do that. I thank you very much for the time you have given today and the insights you have provided.

The CHAIR: Thank you, doctors. We could probably usefully have you for another half an hour or more to continue to drill down into this, but time has beaten us. I sincerely thank you on behalf of the Committee and all members of Parliament for the outstanding work that you do at the coalface looking after the citizens of the State. You may not get those thanks very often, but we understand the amount of work you do, particularly in recent times in the past 2½ years. We sincerely thank you for that. We also sincerely hope that this inquiry will produce a report with some recommendations which will hopefully add to the downward pressure on what are obviously enormous challenges you have. Hopefully we can improve things over time.

Thank you very much for making yourselves available today. It's been very helpful. I expect there will be questions that Committee members would like to pose to you as supplementary questions, following the opportunity of members to read the transcript. If you would be agreeable, our Committee secretariat will liaise with you and that will enable them to follow up on some of the questions that we have started to explore in the hearing this afternoon. Once again, thank you very much. Please pass on those thanks to all the people in NSW Health who equally support you and work with you.

(The witnesses withdrew.)

Mr GERARD HAYES, Secretary, Health Services Union (New South Wales, Australian Capital Territory and Queensland), sworn and examined

Ms LAUREN HUTCHINS, Assistant Secretary, Health Services Union (New South Wales, Australian Capital Territory and Queensland), affirmed and examined

Ms SHAYE CANDISH, General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

Ms KELLY FALCONER, Registered Nurse, and Member, NSW Nurses and Midwives' Association, sworn and examined

The CHAIR: Thank you all very much for making yourselves available to come along this afternoon. You're all very busy people and you've had to carve out time, in addition to preparing or overseeing the preparation of the submissions, to come this afternoon and give your time. We're very grateful for that. I confirm that we have gratefully received the submissions from both organisations. They have been duly processed and uploaded to the Committee's webpage, and stand now as evidence to the inquiry. For the Health Services Union, that is submission No. 34, and for the NSW Nurses and Midwives' Association that is submission No. 31. You can take those two submissions as read. We have them here to refer to if we need to. I invite you now, if you are agreeable, to make an opening statement—one from each of the organisations. Then we will open it up to questions from the Committee members. There are members from the Opposition, crossbench and Government here. We will take the opportunity to speak to some of the matters raised in your submissions. But we look forward to your opening statements as well, to stimulate some discussion too. Mr Hayes?

GERARD HAYES: Thank you, Chair. HSU has had a significant interest in health outcomes from a paramedic, health worker, aged care and disability worker viewpoint. To be clear, ambulance bed block or ramping is a symptom not a cause. The effect on the community of ambulance ramping promotes delayed response times, decreased patient outcomes, a potential for longer hospital stays, and increase in stress on paramedics and other health workers. The reasons for these delays are multifaceted and I wouldn't suggest for a minute to be able to quantify them today: workforce resourcing, cost-shifting between aged care and health, aged-care funding responsibilities, supply and demand issues, NDIS support, exploitation and profiteering. The Government has announced an extra 2,750 paramedics. However, unless there is an innovative program for pre-hospital care, the opportunity will be lost with respect to decreasing the presentations at hospitals.

I note that the HSU is meeting, as we speak, with the Ministry of Health to promote community-based outcomes that would limit presentations and promote community paramedic engagement. The issue of ramping can be addressed and was addressed by Susan Pearce, the current Secretary of the Ministry of Health, in 2016. It's important to note that around that time ramping or bed block was out of control. The ambulance would have ambulance release teams [ARTs] to be able to facilitate an opportunity. Focus by Ms Pearce and the ministry at that point in time decreased wait times in hospitals dramatically. Following that, COVID comes along and we now have the problem back again. So it's not as if it can't be addressed; it can be addressed, but there needs to be a will to make it addressed.

However, unless there is a royal commission into where the health dollar is currently being spent, and identify the wastage, the blockages and the profiteering, the health system will continue to suffer. There will not be enough money to be able to prop up, bearing in mind the health system now spends one-third of the State budget. I don't think we can afford 50 per cent of the State budget. Thank you.

The CHAIR: Thank you, Mr Hayes. Next opening statement, thank you.

SHAYE CANDISH: I would like to thank the Committee for this inquiry and the opportunity to provide evidence today. There is no denying that demand on our hospital and health system has increased dramatically, as has the complexity and acuity of patients. More patients are presenting to emergency departments via ambulance, and ramping times have worsened. The detrimental effects of ramping—including risk to patients, hospital staff and the ambulance service—led to the introduction of key performance indicators to keep track of ED activity. However, an unintentional bias developed because of these KPIs and many EDs are now viewed as managing primarily on how well their ramping is handled at their facility. This can often drive a culture of treating and allocating beds or spaces to patients who have arrived by ambulance over walk-in presentations, which undermines the process of clinical triage whereby access to treatment is based on acuity or need.

Flow throughout emergency is a balanced responsibility of the nursing and medical staff to manage demands of the ambulance service and the waiting room. In collaboration with hospital and ambulance management, flow coordinators attempt to create movement in the department while considering KPIs focused on ramping length and treatment of patients, with consideration of benchmarks. The reality, of course, is that the ability to influence ramping and patient care within ED is almost entirely dependent on the capacity of the hospital

beyond its emergency department. The system in which our nurses and midwives find themselves now is one of dysfunction. The issues are never isolated and tend to be cyclical in nature. The wards and units within a hospital are constantly pushed to discharge patients, often too early, for follow-up in the community.

The community system is also under strain and, at times, struggles to follow up patients and maintain thorough and consistent care. This results in readmissions via the emergency department, which then adds more pressure to ambulance services and, once again, wards and units. This is the nature of access or bed block. To address ramping times and access block, nursing staff are pushed to offload ambulances into treatment spaces that are often termed "transfer-of-care beds". This allows the ambulances to get back out on the road, but also creates more issues around ramping when they return if the transfer-of-care bed remains full—and often this occurs. Access block leads to patients commencing treatment and monitoring in assessment spaces, which creates additional pressure on medical and nursing staff as their capacity to assess new patients is then compromised.

Access block and overcrowded EDs put enormous strain on clinical staff, resulting in increased work-related stress and decreased job satisfaction. The experience of our nursing and midwifery members is that many are choosing to decrease their clinical hours or leave the profession altogether. The relentless physical and psychological pressures placed upon staff are contributing to the ongoing workforce shortages. Many report workplace fatigue and moral injury. There is no one solution to ambulance ramping and access block. However, improved staffing and skill mix levels in our EDs, inpatient wards and units, and community health care settings must be implemented to ensure safe care can be provided and that sufficient staff are available to ensure capacity within the hospital more broadly to overcome access block. Investment in primary care is also key to reducing demand on acute-care services. Without system-wide reform, we will not achieve the improvements necessary to deliver better health outcomes for all involved. I would invite Kelly to talk to the local clinical issues as well.

The CHAIR: Thank you. Ms Falconer?

KELLY FALCONER: Good afternoon and thank you for inviting me to share my firsthand experiences of ambulance ramping and access block within the New South Wales public health system. I am in my twenty-fifth year of nursing and 21 years have been in the emergency department. I am employed as a clinical nurse specialist and have advanced practice nurse skills, advanced life support in adults and paediatrics, and education qualifications. I am very experienced in my field, highly regarded by my peers, leaders, managers and medical specialists I work with. There are not many of my kind left in the ED. My work ethic is second to none. I am a proud nurse and deliver a high standard of care each and every shift.

However, never in my 25 years have I felt as unsafe in my career as I do now. The past few years have proven to break many experienced nurses. We were already at breaking point prior to COVID, and COVID has just exacerbated this. They are leaving the profession due to many reasons, but mainly because of increasingly unsafe workloads, unsafe working environments with increased aggression and violence, and unhealthy work-life balance due to constant demand of extra and overtime shifts. It saddens me to be here today. How and why did it get this bad? Why are they not listening to us experts on the floor? I literally work in a war zone—not on the battlefields, but the war zone that is the emergency department crisis of today. It is a product of a completely broken system: from limited GP access to cost of GP access; not enough beds for ever-developing growth areas; staffing shortages, both nursing and medical; limited mental health access; limited ambulance access; higher acuity patients leading to longer waits; and increased violence and aggression. I am speechless and overwhelmed on most of my shifts, and with my experience that says a lot. We are placing critical patients in non-staffed areas as there are no places for them to go to be treated apart from the waiting rooms.

Some of the issues I have come across include patients with chest pain being treated in recliner chairs—non-staffed, mind you, and having cardiac arrests—allergic reactions and croups being treated in triage amongst other waiting patients, being given adrenaline to keep their airways open; patients with mental health issues being physically and/or chemically restrained in amongst patients waiting on ambulance stretchers, watching in fear; junior staff members in non-acute areas looking after critically unwell patients, giving them life-saving infusions such as adrenaline; and five-minute lessons on how to use equipment in non-resuscitation areas, such as BiPap—"I am sorry, you just don't fit the critical area right now. You're going to have to be nursed in the non-acute area by a nurse who was told in five minutes how to use the machine."

A patient with a leaking abdominal aneurysm waiting in the waiting room for three hours before a CT, only to find out it has been leaking, and then lights and sirens to a tertiary hospital for surgery; cardiac patients admitted to the cardiac wards with no cardiac monitoring; elderly patients developing pressure areas because they are made to sit in recliner chairs for in excess of 24 hours; and patients requiring specialist care moved to tertiary hospitals for neurology, orthopaedics and oncology, sitting in our department for in excess of 24 hours and sometimes up to 70 hours. All of these incidents are real. I have lived these experiences. These outcomes can lead to death. Increased falls, medication errors and moral injury are a direct result of the increased pressures placed

on our health system and staffing. Our patients deserve the world-class health system that they have been promised and right now we feel like we are working in a Third World country. Thank you.

The CHAIR: Perhaps if I could kick off with questions, specifically to Mr Hayes. Can I take you to the submission and particularly the conclusion, because I would like to link up comments in the conclusion with an aspect of your opening statement. I won't read the conclusion paragraph in detail, but if I could pick a part from it where you say:

> … our members report is always the crucial issue of insufficient material resources and inadequate staffing levels, which in turn make for employees who are increasingly subject to excessive workloads, inadequate training opportunities and workplace stress.

Clearly what is there is a wicked problem and something that obviously in your role you have observed over a period of time. Can I ask you, is it out of sheer and utter frustration of not seeing an improvement that you quite expressly made reference in your opening statement to a need for something no less than a royal commission—to actually look at the totality of the universe, if I could put it that way, that's confronting us?

GERARD HAYES: Absolutely. I have been involved with health since 1986, being a paramedic for some years before coming into the Health Services Union. I have been before many of these inquiries and before many of you. We look at trying to find the answer, but we don't look at where the problem is. There will never be enough money. We will be coming into an election soon and people want more money. We can't have 50 per cent of the State budget going into health. I think fundamentally what we need to be doing first is look at where this money is going now. Where are those choke points? Where is that wastage? Where are people taking money where they shouldn't be taking money? If we can resolve those issues, then we can spread the health dollar out. As I said 2,700 extra paramedics by the Government has been very well received.

The Opposition is talking about an extra 500, which again is well received, but the fact of the matter is it will not change a thing in terms of hospital access block due to the fact that, as has been indicated already today, what's going on in the hospital is showing—as an observation from outside the hospital—as ambulances ramping up. It's because they can't get in and because they can't offload. It's that handover of care, which is vitally important. We're subject to disputes at the moment. We don't want ourselves or nurses to be in harm's way on a handover of care. These things are becoming a daily issue and they are certainly a legal issue when someone dies. Issues that have been raised already here today occur regularly and have been getting worse for many years. So we can continue to say, "We will put some more money here and more money there," but there is no more money at the end of the day. We have to get to the root cause of why one-third of the State budget isn't sufficient to deliver a quality health service.

The CHAIR: Can I ask you this—and I think I know the answer, but just to confirm it—with respect to the members you represent, which are well known within the health system and are broadly defined, but particularly in this context of public health and public hospitals, are members putting it to you in such stark terms that they have never seen it as worse as it is—that kind of very definitive statement?

GERARD HAYES: Absolutely. I think every crisis is an opportunity. From 2020-22 the pandemic was here. It outlined the lack of resources, the under-resourcing of health. Whether they are allied health professionals who are exhausted, whether they are people who are admin officers at the ED who are being abused every day, the violence that is presenting within hospitals—these things have manifested up until 2020. We are coming out of COVID now. Those issues of normal flu, winter bed block and violence in hospitals will start to ramp up. But at the same time, we have now got a workforce that is depleted and I would think, for the next 12 months, attracting and retaining people in the workforce is going to be even more difficult. So it is a matter of urgency that we don't look at this in a piecemeal effort, but that we look at it overall, particularly when you look at aged care. The cost shifting in aged care alone is just remarkable. We did a GIPAA in the Illawarra area and found that 8.6 per cent of beds were taken up by aged care residents. At the same time we found that 210 registered aged care beds in the community were given back to the Federal Government. So we have a decreased aged care opportunity. That flows on to the public health system, and that is not funded by the Federal Government, so there is another major issue.

The Hon. ROSE JACKSON: Thanks so much for coming along. I wanted to start just quickly—it was raised earlier, perhaps to you, Mr Hayes or Ms Hutchins—on this term of "ambulance ramping". In a way it makes it sound as though it is just a vehicle sitting on a ramp somewhere. It kind of hides what we are actually talking about. I wondered whether you have a reflection on that. We use that term, it is almost a clinical term, but it is not really an accurate term, is it? Because it is not just a vehicle sitting on a ramp somewhere; it is paramedics frustrated that they can't get to the next call or a patient lying there who can't get the treatment they need.

GERARD HAYES: It is a clear identification of, to my view, malpractice of a patient. Someone who was of the view that they needed emergency ambulance transport to get to a hospital and we hurry up and we wait. That means also that that person who needs an ambulance isn't going to get one because the ambulance is still at

the hospital. So as I said, it's a symptom, it's not the cause. But it is a frustration. Then you look at paramedics who are doing 15- or 16-hour days before driving to and from work, and the exhaustion that comes along with that. As I said before, the violence is starting to increase again.

Our members at times rub up against the nurses, and not in a good way, because everybody is so exhausted. Everybody is trying to do the right thing, but clearly there is only so much room in an ED for a patient. Then we have to have other people coming in over the top trying to resolve that matter. I really wanted to make that point at the outset. This was dealt with by Susan Pearce in 2016. These things can be dealt with again, but there has to be a 24-hour, seven-days-a-week focus to resolve these matters, and I don't think anyone has been supporting that at all.

The Hon. ROSE JACKSON: Is that what led to your call for something of the size of a royal commission even to ensure that that focus is necessarily given to this issue?

GERARD HAYES: I'm sure everything that you've heard and everything that you will hear—there are so many competing interests in health. But this is a universal healthcare system. It can't be universal for some and not for others. Whether you're regionally based or you're metropolitan based, we should be able to make sure that that public health money—taxpayer money—is spent wisely and is not gouged. If there are blockages within the system, why don't we look at the back end first? Why aren't patients discharged early so that frees up a bed for someone to come through? Why aren't there enough diagnostics so a patient isn't waiting in the ED for medical imaging or waiting for pathology? On and on it goes. You will see in our submission that pathology, it's just cutting back as much as you can. That's telling you all the time there's not enough money. But there's got to be enough money. It's one-third of the State budget.

The Hon. ROSE JACKSON: I wanted to ask you a question, Ms Falconer. It was incredibly powerful evidence. Thank you for telling some of the stories that you've experienced. I know that you're not a very inexperienced nurse; in fact, you're an incredibly experienced nurse. If that's what you're dealing with, can you reflect on what it's like for someone who doesn't have 25 years of knowing how to respond to a rapidly deteriorating situation and a high-stress environment? What's the lived experience like for a new nurse? Again, we hear about new nurses coming into the system—that's great—but what's their experience like and are we ging to be able to retain those new nurses, considering what it's actually like in ED at the moment?

KELLY FALCONER: My experience 25 years ago was amazing. I had extremely senior people watching everything that I did, teaching me everything I know. I am the nurse I am because those people built me up to be who I am today. The nurses of today don't have that—not even a little bit. I cannot stand there and watch my junior staff members doing everything that they're doing because I have my own patient load, and then some. We're constantly over census. So not only am I looking after the beds that we have staff for, I'm looking after beds that we don't have staff for, and I'm talking resuscitation bays. If we've got a one-in-one in resus, we have four beds in there, we have three staff, and one is a non-funded bed, we're constantly full with four critically unwell patients.

When I first started going into the resuscitation bays, I always had two senior staff with me side by side, constantly telling me what to do, showing what to do and explaining when something wasn't going right why it's happening. I can't afford to do that today because I'm looking after two critically unwell patients. So it's a five-minute session. Half of them aren't even advanced life support so they don't have the skills to give medications when required to because we should be there with them, teaching them at the time. Most hospitals don't have that. There's a lot of inexperience, there's a lot of crying, there's a lot of sick leave and there are a lot of threats of "I can't stay. I can't do this any longer." We've got nurses that are leaving with less than five years' experience. To have someone with 25 years' experience working in an emergency department is practically impossible these days. We've just had 14 staff members leave with over 20 years' experience since July.

The Hon. ROSE JACKSON: Wow! That's amazing.

KELLY FALCONER: They don't want to deal with this anymore. They can't deal with it. Every day that one of those junior nurses goes on the floor and gets her patients, she is risking her registration: every single day making decisions which ultimately may end her in a Coroners Court explaining why the patient died. It's no fault of the nurses; it's a system that's failing.

The Hon. EMMA HURST: I might start with Ms Candish. I was really struck by a quote from one of your members that you included in the submission. They said:

> Insufficient staffing in ED is unsafe. Staffing in our ED is reliant on us doing overtime which is causing burnout and sick leave. The constant pressure from management to have a plan to offload ambulances is so stressful. How can we have a plan if there is nowhere for them to go?

Can you flesh that out a bit more for us and the link between understaffing and the bed block, and how the staffing ratios are so important to improve this situation?

SHAYE CANDISH: Yes, sure. Earlier Ms Jackson asked a question about the visual of ambulances outside. For an emergency nurse, of which I am one as well, you measure your day based on what that ambulance waiting bay looks like. Driving your car past as you go and park in the parking lot, if there are eight ambulances lined up you know the type of day that you're going to have before you've even stepped foot in the place. That's reflective of the emergency department that you're walking into but, more broadly, the hospital. It's really just this compounding impact of eight ambulances lined up, as an example, meaning eight patients waiting to be offloaded. You can guarantee you have a full waiting room as well, so that already tells you that there is not flow available throughout the hospital.

For nurse managers, nurse unit managers and senior doctors, who are responsible for having the plan that you spoke about, it's incredibly stressful and there's this kind of internal process of escalating phone calls and escalating stress across the ambulance service and the local hospital management, pushing for a plan to be created. But, frankly, you're trying to create something out of thin air because if there are no more beds where do the patients go? That's where we start to see the usage of beds, like what Kelly referred to, that are unfunded. We see hospital wards that are not in use opened up and patients offloaded into those. We see patients put into corridors, we see patients put into chairs—all things that go against what we would consider appropriate within our clinical judgement. But it is done in an effort to try to offload the ambulances because we all know it's critical that they get back out onto the road as well.

But we're doing all of this, continuing to take on more and more patients, without the appropriate staff in a number of settings—in most settings, in fact. It just escalates the stress that everyone is having to work within. Inevitably, it means that you're taking on more patients than you can care for. You're rationing the care that you're offering. If I'm a nurse who has eight patients and I'm taking on two more, I can't just give more care to two more people. I don't have any more hands. So I'm now deciding who gets prioritised.

When people come through an emergency department, yes, they've had a very comprehensive triage and, yes, they might've had an assessment, but when you're seeing this overall bed block and incredible demand placed upon this environment, everyone's operating in a climate of doing the best they can but inevitably things get missed. Often you don't have, at that point, very comprehensive medical history and you don't have pages and pages of patient details, in terms of their observations. You don't have a consistent record. So you're really trying to make judgements based on very minimal amounts of information. When you then overload that nurse with more and more responsibility, their capacity to monitor and to intervene when something goes wrong is also diminished.

The Hon. EMMA HURST: Mr Hayes or Ms Hutchins, there was also a story in your submission from one of your members who had an elderly patient die in the back corridor of a major tertiary facility due to bed block. Obviously, it's clear from the evidence that we've received that patients' lives are being put at risk in the health system, as it's currently standing. Are you hearing stories similar to that example? Is this a situation that's going to continue to get worse and we're going to continue to see patient deaths in a similar manner?

LAUREN HUTCHINS: I just want to note, in terms of that story, that that was an elderly patient who had a "do not resuscitate" request—just for completion of that story. However, that paramedic who was treating that patient has to go home at the end of the day thinking about the way that patient passed and the lack of dignity in that patient's passing. When you enter the hospital system, you enter for help. You enter thinking that you will get that help. You don't enter the system thinking that you will be sitting in a corridor for hours waiting for a pathology report to come back to diagnose you. When you're in the system, you don't think that you're going to be pushed through the system to be exited as quickly as possible so that a bed is made available.

The system is broken. We have members, social workers, who talk about the pressure to have patients released. Imagine that as a social worker—thinking that you haven't been able to actually provide the care and support that you think is necessary, that you have trained for. That is a system that is broken. That a third of the budget can go to a system that delivers those outcomes is really confronting. Gerard spoke about aged care. We have beautiful facilities in the South Coast where two-thirds of the building haven't been opened. We have residents that sit in hospitals because there aren't GPs to treat them or there aren't adequate staff in aged-care facilities to ensure that they get the care and support they need. This is a whole-system problem that we need to address, and the only way that we are going to do that is to look at every part of it.

Ms CATE FAEHRMANN: Thank you all for appearing today. I go back to a comment that the health Minister made in March at budget estimates that we have been asking a few witnesses about, where he said that ambulance ramping "is actually very rare now in New South Wales". I think we have enough evidence from all of the witnesses that that is a ridiculous statement. But in the sentence before that, in response to a question that

I asked about the fact that 12 ambulances were ramping at Westmead and were off the road and that this was happening night after night, he said:

> I think it is fair to say that from time to time all hospitals will have some issues, particularly if you have COVID patients in the emergency department, and that is the nature of being in a one-in-100-year pandemic.

Do you think our health Minister has any clue as to what is happening in the emergency departments in our public hospital system every single day in this State? I'll start with you, Mr Hayes.

GERARD HAYES: I think he does. I've been through a lot of health Ministers. Some have been very poor, and I think Minister Hazzard has generally been across his brief. However, I'm not going to be an apologist for people, but the pandemic is something that we've not been through before but has clearly identified our shortcomings. Those shortcomings didn't come in the last two weeks; they came over the last 10, 12, 14 years, and we need to take ownership of that. Health has been under stress for the last two years. Health was under stress before the last two years. As I said before, in 2016 ramping was so bad that Susan Pearce had to get involved in that. To be fair, it's probably a comment that could have been made better. But to your point—in terms of covering a whole heap of issues over the past, particularly, two to four years and my dealings with previous health Ministers who were incredibly poor—it's a hard job.

Ms CATE FAEHRMANN: Ms Candish, what's your view? Just to be clear, he did say that ambulance ramping in New South Wales was "very rare now", and he also said that it's really as a result of a one-in-100-year pandemic that this pressure is now on our hospitals. What's your view? Does our health Minister have any clue about what's happening in our public hospital system?

SHAYE CANDISH: I can't comment about what the Minister does or doesn't know but, definitely, that comment doesn't fit with the evidence. There's a clear contradiction there; it doesn't fit with the Ministry of Health's own data. The BHI data that was released recently is the worst data that's been on record since that BHI data was being collected. I think at any point, when you look at the volume of data that's available, there is no evidence that indicates that it's a rare event for hospitals to experience ambulance ramping. I don't believe that it's specifically in relation to the pandemic, either, because this has been a worsening circumstance that we've seen for the best part of the last decade.

Again, the complexity of the situation means that it's difficult to attribute to one specific factor. But the pandemic has certainly escalated a number of these factors that we've been discussing for many years in relation to increasing demand, lack of appropriate staffing aligned with beds and the complexity and increasing acuity of patients with a number of comorbidities coming through a hospital system. Having a system that fundamentally prioritises acute care, with very little investment in or focus on primary care and health prevention measures, means that we're continually having to pour money into a system that is constantly dealing with people at their sickest, rather than focusing on how we might start to prevent the increasing or worsening of health conditions before they're requiring acute care.

The Hon. WES FANG: I note my time always seems to get compressed right at the end because everyone takes so long with their questions. I know we're about four minutes from the break, but I have a few questions.

The CHAIR: No, you won't be short-changed.

The Hon. WES FANG: You've been very generous about that, Chair, and I appreciate that. I will start with you, Mr Hayes. I appreciate your candour when you provide testimony to our inquiries. I don't know if it's because you've been in the role for as long as you have, but you try to cut through things. You made a really good point when you said that at the moment we spend about a third of the budget on health, and we don't want to see it go to half. There's obviously a lot of money there, and it's perhaps an issue around where it's spent. I note you said that we've had some under-resourcing. Do you have some views as to areas where there might be over-resourcing in the budget that can be shifted to assist this issue?

GERARD HAYES: I don't think you can shift anything in the budget until you find where the money is going, and I don't think it's over-resourcing; I think it's who's taking the money. Under-resourcing comes because there's no money left, and that's my major concern. We can look at regional New South Wales, which you clearly understand. Would it surprise you to know that a person being a locum going to regional New South Wales could be being paid $4,000 to $5,000 a day? How do you do that? How do you attract and retain people? I can't emphasise it enough, and I know I'm really labouring the point here. We can get into the minutiae of all of these different people who will come before you—all the different organisations. But you will not get to the point of satisfying the people of New South Wales in relation to good health outcomes—a good workforce that actually is complementary and supportive of the whole system so we can effectively get a conveyor belt that moves out of the back of an ambulance, through an ED, through medical, through surgical, into the discharge lounge and out

efficiently. But we can't do that when others are taking money out of the system, profiteering out of the system. If we do not deal with that, we cannot deal with the crisis that's before us.

The Hon. WES FANG: I would say the members that you represent are some of the lower paid workers in the health system, as well as paramedics. We've heard from the APA already today, but I think you're the pre-eminent paramedic union, along with them—there's obviously that debate. Do your members have a view about other parts of the system staking claims about what's required? They might have a different view, for example, on nurse ratios when one union is saying that we need to put more money in that area and that that will make a difference. We know that the Labor Party has not backed that solution. Do your members have a view on that?

GERARD HAYES: Yes, I think we do and, personally, I do. I've got two daughters who are ICU nurses, so I sort of get it. What we look at is a holistic system that is complementary. Nurses deserve to be able to work safely and to be able to make sure that their patients are looked after without them potentially going to a coroner's court. I think that what was said earlier on is absolutely true: Those issues are really there. Our concern is that it's also incumbent upon a good health system to have the right diagnostics. Someone is not just sitting in a bed because there's one person doing medical imaging, there's one person doing pathology and there's one person pushing a patient from A to B. We see it as a holistic system where one group relies on another group. If that system doesn't work collaboratively, it just becomes chokage point after chokage point. So we fully respect the nurse ratios, as we fully respect the incredibly difficult workloads that they have and the incredibly difficult worries that they have as a result of that. At the moment, we are trying to get to a holistic outcome from the system, not just looking at different aspects of that system.

The Hon. WES FANG: Would it be fair to summarise that as that every aspect of the healthcare system is able to be better resourced, but focusing on one part of it and not others perhaps will not lead to the outcomes that are promised, that we need to look all the way from the cleaner and the store right through to the CEO and the surgeons?

GERARD HAYES: It just makes absolute sense to be able to do that. But if we don't, we're kidding ourselves here today. We seriously are. We have to get to that point to be able to see that that money is there. It wouldn't surprise me if it got to 28 per cent of the State budget, but if we're going to sit there and just throw money away and not be overly accountable for it—I challenge anyone to support me on this. And I'm sure there are a lot of people who won't say much but will support me on this, because nobody wants to get into this fight. And we have to get into it. Otherwise we will revisit this, our kids will revisit this and people will keep walking away from health altogether. And it's such an important fight to have. If the last two years hasn't taught us anything, it should have taught us to have the guts to have a go now and resolve this problem.

The Hon. WES FANG: There was one other question I wanted to ask. It came from Ms Candish or Ms Falconer, I can't remember. But it was about GP access and how the inability to access GP services was providing a pressure point for EDs. And we know that that's obviously the case. We're in a system at the moment where, for example, hospital systems are obviously State based but things like GP services are federally funded through Medicare. So it might be the primary health networks that have interaction at that level. So it's probably more a lever that's being pulled by the Federal Government than, say, the State Government. Would you have any views as to what the Federal Government should be doing in this space in order to provide more and better GP services to those patients who would ordinarily go to a GP but are struggling and therefore end up in an ED?

SHAYE CANDISH: I think the separation of funding is a matter for each of the governments to work through. An individual person's access to care from their perspective is irrelevant around how it's paid for. And this is one of the challenges in how governments work together. I think the challenge that we see is it's not unique to GP services. We need a much more comprehensive approach to primary care more generally. There's a space for nurses in that role as well. We saw a really great example of what happens when we have comprehensive and thorough planning and stakeholder engagement through the pandemic, when we saw the immediate mobilisation of vaccination clinics, as an example. So it can be done, but it requires political will. These are going to be critical points for consideration when it comes to regional access to health care, as an example. Maybe a GP is not the best option. Maybe considering GP co-payments is an important way to give GPs more access, more capacity, but not every situation is a one size fits all. I think taking a cookie-cutter approach is going to be really challenging, because different communities require different things.

The Hon. WES FANG: I couldn't agree with you more, but the point that I was trying to elucidate with you is that it's not just a lever that the State Government can pull alone. You've identified that GP access is an issue and means that there is some buy-in on this from the Federal Government perspective. And so there needs to be a commitment from the Federal Government to assist, and that will reduce the pressure on EDs itself.

SHAYE CANDISH: Absolutely. And hospital avoidance is going to be critical, but nurse practitioners are a component of that—nurse-led models.

The Hon. WES FANG: Absolutely.

SHAYE CANDISH: There are a range of options. If I could also just respond to the comment you made earlier in relation to nurse ratios. From our perspective it's not either-or. A comprehensive approach to looking at health care is critical. Staffing nurses in a ratios model is also key to that. That's around putting some parameters around what safe care looks like, because we will continue to see our system overwhelmed. Allocating nurses in line with those patients is a way of making sure they receive care. When we go in and we do that analysis of what the hospital system requires, if it determines we need less nurses, then ratios would obviously afford that, but if it requires we need more, then ratios would afford that too. So it doesn't need to be one or another.

The Hon. WES FANG: Chris Minns and Ryan Park don't agree with you, that's all.

The CHAIR: Thank you all for coming along. It has been very helpful and very insightful. The submissions were very good, but that exchange back and forth with some of the minutiae of specific experiences in the context of the broad workforce that both unions represent has been very helpful. On behalf of the Committee and MPs in general, I thank you as the leaders of your respective organisations for the work that you do with the members in working with them, helping them and guiding them during the difficult times. We know that they are very much on that leading edge and it has been a most challenging 2½ years, so we would like to pass on our thanks via yourselves to them. So thank you very much. I expect committee members may have some supplementary questions arising from the engagement with yourselves. Our secretariat will liaise with you once the *Hansard* becomes available. Thank you very much.

(The witnesses withdrew.)

(Short adjournment)

Dr SUE VELOVSKI, General Surgeon, and Committee Member, Rural Doctors Association of NSW, before the Committee via videoconference, sworn and examined

Ms SUZANNE MELCHIOR, Senior Registered Nurse, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you very much. What we'll do now is invite you to make opening statements. Just before you do, can I acknowledge and thank the Rural Doctors Association of NSW, who over a period of time with different inquiries have been very helpful in their contribution. I remember, in a recent inquiry into regional and rural health, Dr Evill presented evidence to that inquiry and spoke to the submission of the organisation. It's always been very helpful.

We've received your submissions. They've been processed. They stand as submissions No. 32 and No.12 to the inquiry and have been uploaded to the webpage and, obviously, stand as evidence to the inquiry. So you can take those as read by members around the table. They'll be very useful. I'm sure they're going to stimulate some questions from members when we come to that part of the session. But, if you're agreeable, what we'd like to do is invite you to make opening statements. Try and keep them to just a few minutes. Then, from there, we'll go around the room. There are members of the Opposition, the Government and the crossbench here. There'll be a desire from members from all those groups to ask questions. I think that's all I need to say. I'll pass it over to Dr Velovski first for an opening statement.

SUE VELOVSKI: Thank you. I'm making this statement on behalf of the New South Wales Rural Doctors Association, which represents rural and regional doctors and has done so for the past 30 years. It's an association that was initially formed when we recognised emerging threats both to our rural patients and our rural doctor workforce. Probably a lot of what you're about to hear is similar to what we presented in the inquiry to the rural and regional health outcomes. Many of the issues or challenges, as we like to say, in terms of facility, workforce, both hospital and community, and organisational and systems problems have already been addressed in the inquiry. It's no surprise that the same challenges feed through into the problem of ambulance ramping.

For us as both local community members and clinicians, ambulance ramping is not new. Overcrowded emergency departments have been a feature of the healthcare system for many years. We are aware of papers from emergency department research that point to a lack of beds in hospitals, and patients to be admitted to the emergency department. That appears to be a considerable factor in the problem. Over the many years that I've worked as a specialist, as a surgeon, it's only become worse. As a rural doctors' association, we get a number of concerned clinicians worried about the safety of their patients in rural and regional Australia and particularly New South Wales.

There's a perception, a rule of thumb, that it might be considered the number of ambulances ramped is the number of extra hospital beds needed. Those hospital beds may sometimes be available, but our busy and hardworking nursing staff are not. That problem has only become worse during COVID, but it also existed pre-COVID. Examples that we get from the New South Wales Rural Doctors Association are patients waiting in ambulances, who have already been diagnosed by their very competent rural GPs with, for example, acute appendicitis. But there appears to be some form of hospital concern or policy to accept that patient because there's no bed in the emergency department, which means the patient then cannot be booked to the theatre, which means that their emergency surgery is then delayed by four, five or 10 hours, which means poorer outcomes that we are always being hounded for in the media. I think there is a lack of perception by the community about why these outcomes are occurring and how they could actually be changed.

There are also concerns that ambulance ramping or bed block occur because at the other end of the discharge trail many rural and regional hospitals now have whole wards of patients waiting for access to rehabilitation or nursing home facilities. Some patients in our community need to stay a few days longer to access services that should be available in our communities. When we speak to our clinicians, both in our area and throughout the State, they contend that the implementation of the Electronic Medical Record has slowed the passage of patients through their emergency departments, whereas prior to the Electronic Medical Record [eMR], emergency departments may have seen between 10 and 15 patients in an eight-hour shift. The difficulty in processing patients through the electronic record may decrease that to half. That's also due to more complex patient presentations.

The lack of access to services in the community also impacts the discharge process, as we have already pointed out. There's no clear evidence that the lack of access to general practice in rural and regional New South Wales has led directly to increased emergency presentations, except in the event of natural disasters. Northern New South Wales has recently had two such natural disasters, where Lismore has lost three of its largest general practice clinics. Some of these clinics service between 10,000 and 20,000 patients per year. Suzanne is shaking

her head. Those patients come to the emergency departments in rural and regional New South Wales to access services that were previously available in GP clinics. The GP clinics see the patients who they were able to because they still, after seven months, have not been able to restart the work that they used to do in such an efficient way and help keep patients out of the emergency departments.

The other concern for rural ambulance ramping is perhaps in metropolitan Sydney. For example, hospitals can go on bypass, but if you're in a rural centre, 800 kilometres from anywhere, there is nowhere to bypass. That's why patients stay in ambulances. I can give you some [inaudible] of hospitals where, for example, the bigger regional hospitals might be funded for 15 patients in the emergency department but are routinely looking after 30 patients. In terms of safety, that would be like a Boeing plane flying 200 passengers when there are only 100 seats available. We're really concerned about the safety and the quality of care that we can provide to our rural and regional hospitals. Suzanne might agree, but some of the reasons this occurs is that there is a perception that the same solutions are being offered day in, day out, month in, month out. There's a perception that we're doing the same thing over and over and expecting different results. Quite a number of clinicians, allied health staff and nursing staff feel that there needs to be better solutions. And other organisations that are involved in the safety and quality of people's care have other solutions, including human-fact science, to try and prove the systems that are clearly not working. I will leave it at that.

The CHAIR: That's been very helpful, Doctor. That's raised a number of issues which complement very nicely what's in your submission. I'm sure that will lead to a range of questions from members when we get to it. Ms Melchior, I invite you to make an opening statement.

SUZANNE MELCHIOR: Firstly, I'd like to start with this: Why undertake the process of making a submission to this inquiry? Why start the process on a working day, as I am today—I'm on shift this afternoon, allocated the triage and in charge of the emergency department. Why press "submit" on my submission that was ultimately with typos, embarrassed that I ran out of time but I still submitted it anyway.

The Hon. WES FANG: Chair, I invite the witness to perhaps turn the video off so that it might improve her bandwidth and stop the dropouts of the audio.

The CHAIR: Did you hear that? That often does help. We can hear you perfectly. Is that okay?

SUZANNE MELCHIOR: Yes.

The CHAIR: We should get clearer audio now. Thank you.

SUZANNE MELCHIOR: Hopefully that helps you.

The CHAIR: Thank you. It does, yes.

SUZANNE MELCHIOR: Why think that this inquiry is going to provide solutions to a problem that I first encountered 20 years ago in another State? Ladies and gentlemen, Ministers and Mr Chair, people will die, patients will have poor outcomes, and patients are staying longer in the departments awaiting transfer, admission or discharge. The ripple effect is that the clinicians working in health are burnt out, suffering moral injury, moving away from the front line of health care or simply walking away altogether. Terms such as "bed block", "access block", "ramping" and "delay to transfer" are common language. No longer being able to direct admit to wards at the base hospital combined with centralising of specialist services away from rural hospitals such that I work at has meant that any presentation that requires specialty input and inpatient admission will be, and must be, transferred to the base hospital or another facility across the border. Ambulance transfers are for something as simple as a CT scan after hours. The effect on the frontline workers when they have all beds full, several ambulance stretchers lined up, full waiting rooms with some people also needing a bed space to begin treatment is, of course, that they are stressed. We're having to blinker ourselves to the presentations on those worst shifts, which we know we can help with but having to attend the highest clinical need only. So begins the process of moral injury.

This small rural emergency department, to my best knowledge, has been experiencing this for eight years. COVID only highlighted the deficits. I do not want to see any more scapegoat mentality towards the workers on the front line. We have, and are, doing our utmost best. We feel that we're bearing the weight of this broken system for the rest of the community. Enough is enough. Change can be made. We are pleased to welcome this inquiry with an openness and hope for the future of health to see an improvement in ambulance access to the emergency departments, hospitals, transfer times and changes to the process of the critical and non-critical patients being transported between facilities.

The CHAIR: There is no need to apologise or discount in any way your submission. It is a very powerful submission written by someone who is obviously very devoted to her vocation in nursing, has been doing it for a

long period of time and brings some firsthand insights into the challenges that we face and some thoughts about what may be able to be done to address it. We thank you for your submission.

Ms CATE FAEHRMANN: Before we go on, Chair, it might be wise to ask the witness, Ms Melchior, to submit her opening statement for the purposes of Hansard because of those dropouts.

SUZANNE MELCHIOR: No problems.

The CHAIR: Ms Melchior, did you hear what Cate Faehrmann said? It was a very good suggestion. That would be helpful. If you can email it to the Committee secretariat at the earliest opportunity, that will enable Hansard, who are very accurate, to check against that and make any corrections. There is still a little bit of dropout occurring.

The Hon. WES FANG: Can I suggest that the other solution to this might be if the witness were to dial in via Webex. That way the phone line might have more stability. Seeing we can't see the witness anyway, there's not a great deal of advantage being on the Webex computer system. It might be better to dial in via the telephone system Webex.

The CHAIR: Does that complicate things?

SUZANNE MELCHIOR: I'll make that attempt.

Ms CATE FAEHRMANN: She did drop out a fair bit, I think, yes.

The CHAIR: That in fact would be helpful, if you understand precisely what's being suggested to you. My expert is nodding and Andrew Ratchford, our even greater expert, is saying it can be done.

The Hon. WES FANG: I wouldn't suggest it, if it couldn't be done.

SUZANNE MELCHIOR: No problems. I will make my best attempts.

The CHAIR: Good on you. Thank you very much.

The Hon. WES FANG: I'm like tech support level two over here.

The CHAIR: Good luck. I delegate tech to anyone under 15 years of age, normally.

The Hon. WES FANG: I'm 44.

The CHAIR: But you're 44, so that's fine. Just while we're waiting for that to be done, perhaps, Dr Velovski, may we commence asking questions of you so the time doesn't just whittle away. Perhaps we'll start with the Hon. Rose Jackson.

The Hon. ROSE JACKSON: Thank you. Thank you so much for your submission and your opening statement. I want to pick up on something you mentioned in your opening statement and in your submission, which is that:

> We sound a word of warning against trying to attribute ambulance ramping to a lack of general practice services.

I think that that is an important point to make because that is something that occurs. There is this idea put out that, particularly in rural and regional areas, the reason we see pressures on emergency departments in hospitals is a lack of GP services and that, if we just had more GPs, the problem would go away. But your submission sounds a word of warning against that kind of simplistic solution. I want you to clarify that and you to put on the record why that is actually a simplistic solution that's not going to solve the problem.

SUE VELOVSKI: Yes. There are long waits to see general practitioners in many local health districts and many rural and regional centres and we do have in our—when we project into the next 10 years—we have far less numbers of resident medical officers looking to a career in rural and regional Australia because it is a very complex—it's probably one of the most difficult specialties, to look after patients with complex conditions as a rural general practitioner. But also—and a lot of rural general practitioners are seeing, per capita in their rural communities, more patients. Longer hours lead to fatigue, possibly error, burnt, not burnt out, not meaning they'll walk away unless there's a significant health issue for them.

We have GPs in, for example, Tenterfield who are in their eighties still working, trying to find someone to take their practice over. And you're right: The ambulance ramping example I gave, the patient waiting eight hours for a bed with acute appendicitis, means that the next patient in the same rural region with chest pain doesn't get picked up because there is no other ambulance to pick them up and bring them to the hospital for the acute care that they require. But we also make the point that we don't want this to be a political football between the Commonwealth, who fund general practice, and NSW Health that funds our State.

This has never been so obvious—and I hate coming back to the floods in Lismore—but those number of practices that were flooded did an enormous amount to keep an enormous amount of patients out of our hospitals. And those patients are coming for GP presentations—for example, for their vaccines for tetanus—because they just—actually, the GPs don't have infrastructure to rebuild their practices. They haven't had the ability to get the grants that are available for small business. There's been a number of major organisations who have called for medical facilities in rural and regional New South Wales and Australia to be considered an essential service because of that political back and forth—GPs being funded by the Commonwealth.

But when people can't see a GP, they head to their rural hospital, which then gets backlogged, and which means that patients, who need to be seen acutely or picked up from an emergency trauma or with chest pain, wait longer, which means physiologically they will have a poorer outcome. There are lots of times and issues in medicine when you treat chest pain, how much time you have to get a really good outcome from a stroke. Every hour of infection in the belly, sepsis, increases death rates by 10 per cent.

The Hon. ROSE JACKSON: Avoiding that sort of political buck-passing in a way was why I asked that question because, as I said, just sometimes there's this simplistic idea of "Oh, it's the Commonwealth's responsibility. They just have to fix the GPs. All these people are presenting at rural and regional EDs with issues that are easily resolved at the GP level. They're not able to do that and so it's becoming a hospital problem." Your evidence suggests that, obviously, there are problems with GP access in regional areas, but actually a lot of the people presenting at hospitals have issues that need to be dealt with in an acute care environment, whether it be a sepsis or a chest pain or an appendicitis. But there are problems in the hospital setting that need to be resolved as well.

SUE VELOVSKI: There are systems in the hospital that could make the work flow better and the benefit—and what I say to the trainees is, one of the beauties of living and working rural and regional, your GPs often will have worked-up that patient so that you don't have to get the CT scan for the appendix. These are GPs who have looked after two or three generations of family. They know the family, the genetic history—everything—and, if we could get that patient out of the ambulance into the emergency department for acute definitive care, we would save thousands of hours of nursing care and doctor care because quite often the GP has done, as best they can, the outpatient work-up for things like acute appendicitis and bowel obstruction. We can do no more than send them to the emergency department. But the beauty of the health system is when it works well and is able to work well because systems don't interrupt that. It's systems errors where rules have been created that are reactive to a problem rather than proactive. There are many other industries that do that when they're looking at safety and quality.

The Hon. ROSE JACKSON: I want to ask my colleague, Mr Donnelly, if he has a question.

The CHAIR: Continue on. You've got another minute.

The Hon. ROSE JACKSON: Okay. Ms Melchior, are you there?

SUZANNE MELCHIOR: I am.

The Hon. ROSE JACKSON: Apologies.

SUZANNE MELCHIOR: Can you hear me?

The Hon. ROSE JACKSON: We can. Excellent.

The CHAIR: We can—very clearly.

The Hon. ROSE JACKSON: I just want to ask, considering the evidence that you've given, the fact that you're taking time out of your shift to give us evidence, which I think is incredibly important in front-line evidence: What does a typical shift for you look like? If you could give us a sense, based on your experience or your work, or an insight into the ED in a regional hospital right now. What's the experience like for the staff and the patients?

SUZANNE MELCHIOR: Sure. Having just stepped off the floor to come to this meeting, I had prior arranged with my manager, he had a nurse covering for me. We started the shift at handover and, in that handover, there was one bed space free with six patients in the waiting room, waiting. The one bed space that was free was because it was a mental health patient, who just ran out of the department, hurling abuse as we arrived, and left. That person has since had to have the police called on them. As we went around the room handover, an example of what Dr Velovski explained, we've got a young female with abdominal pain, who is getting packaged perfectly here with an ultrasound, a CT abdo, formal bloods and she's waiting to be transferred to the base hospital.

The next bed along is a chest pain, who is waiting for a repeat troponin formally. That troponin is a six-hour because we don't have the ability onsite, so that gets collected and it'll wait until the next pathology run,

which is at three o'clock. The next bed is our resuscitation bed. There is a 57-year-old man in there who has been on BiPAP, which is a breathing apparatus to assist with recruiting lung field and improve his breathing. He has been on BiPAP for seven hours and he is waiting for a bed and a disposition. There are currently no ICU beds in our area and there are none on the Gold Coast. At this stage, they are looking as far afield as Brisbane to send this man. He is deteriorating and they are at the moment contemplating intubating him to stabilise him further. But he still doesn't have an ICU bed to go to.

He will potentially continue to be managed here in this department. He has been allocated one nurse and he has an additional nurse for one-on-one nursing, as arranged by a manager, which is very fortunate. We have got agency nurses covering gaps at the moment and it had a skills agency nurse available and she is here until eight o'clock, at which point her shift ends. If that patient hasn't been retrieved or taken to an ICU, it'll be then one of us having to come off the floor and continue that one-on-one care, leaving the other areas short.

In the waiting room, we had five patients over 85 years of age, who were here for various different ailments. The average wait was 3½ hours. We had a lady who has been here 17½ hours waiting for her imaging and pathology results because she had some abnormality. She is stable but she is still waiting and that bed space is occupied by her for that length of time. We had a lady who was waiting for patient transport, which was arranged and available to us today, which is not always the case. Her patient transport stretcher was reallocated to one of these elderly patients who had a fractured neck of femur, as it turned out, who had been sitting in the waiting room in a wheelchair.

This was essentially the handover at one o'clock, with a full department ready to go. As I came to this meeting, we had moved a number of those beds and some discharges had happened. There were three ambulances arriving. I did one of those triages and allocated the bed to that patient, leaving only one bed free in the department. There were two ambulances ramped—let's use the word because that's what it is. One of those has been offloaded and there is another one currently who is probably clocking up 25 minutes now waiting to be offloaded. This is not an extreme shift; this is a normal shift most days of the week. There is not one particular day in the week that is busier or less busy than others. I work a lot of night shifts as a personal choice to try and stay away from some of the management aspects of decision-making that go on when there are just too many cooks, and it also works for my family.

Up until recently, this emergency department with nine beds in it had only one nurse on a night shift with a doctor. It was heavily reliant on the after-hours manager to plug the gap. We have now been 18 months with two nurses on night shift. Over the weekend—being a long weekend—the executive director allocated an additional nurse on three of the night shifts that I worked, and we did not stop. Those three nurses were busy at the bedside with clinical care for that full 10-hour shift, each one of us.

I am painting a picture of what I know, having been involved with the nurses' union. I have spoken to other similar sized or grouped emergency departments in the State and this is not an issue that we are just experiencing here. This is statewide and this is actually nationally an issue. One of the things that I see which really challenges us here—and Dr Velovski touched on it—is regarding GPs who package up their patients but they can't make it through the bottleneck of the emergency department. That happens here in our facility also. We have highly trained FACEMs on two shifts in the day, as well as highly experienced locums or CMOs or registrars in between.

I can tell you that the majority of the time these patients leave us with the full diagnosis and the full work up, with reported CT scans and ultrasounds, and yet they have to go through the emergency department at the base hospital. No longer, in the 20 years that I've worked here, are we able to direct admit to the appropriate ward area and specialty area. I think that's a systematic thing that needs to be revisited thoroughly. If there is a bed for that patient—i.e. if there is appropriate nursing staff to care for that patient in that bed space in the base hospital ward—we should be able to directly transfer from our emergency department to that specialty on that ward and bypass the emergency department. There should be no need for us to be sending patients who are waiting for their neck of femur to be repaired, who are waiting for their appendix to be taken out or who are waiting for their coronary care bed to free up. We should be able to directly admit. That's something that I've seen has grossly changed in the 20 years that I've been here. Is there anything further?

The CHAIR: That has given us much to reflect on.

The Hon. EMMA HURST: Thank you, Ms Melchior, for your time today. I can't imagine how stressful it is for you calling in while you are on shift. You noted in your submission that there are no CT scans or ultrasounds available after hours or on weekends in your ED. Can you talk us through what happens in your department if somebody comes in on a Sunday night and urgently needs an ultrasound? What delays is that person going to see?

SUZANNE MELCHIOR: Absolutely. That is a common thing. We service a really high area of aged-care facilities and nursing homes and two of the core presentations we get from that demographic are falls and abdominal pain. You are right. The two things that are acutely diagnostic for that elderly and frail patient are generally a CT scan of their brain or their abdomen or even an ultrasound of their abdomen. If they come in, let's say, at four o'clock on a Sunday afternoon and it's identified that they need a CT scan of their head because they've maybe got an obvious injury or they've simply hit their head and they are on blood thinners, as the majority of elderly people are who have comorbidities and issues with their health—and we would also ask why they fell. Maybe the CT scan isn't because they are on blood thinners; maybe it's a diagnostic tool to ask the question why did they fall.

If we don't have CT scans, our FACEM or our doctor here at this level will phone to Lismore and say, "This is the situation. We're going to send them up for a scan." After hours, generally, we don't have access to patient transport vehicles. Let's say if there is a head injury with neck pain, the patient transport vehicles don't actually have a scope of practice where they would transport patients who had a neck collar on, for instance. Those people would have to be booked for transport and, generally speaking, that transport is most suitable in a safe way for that patient so they don't have any more falls or risk of injury in an ambulance stretcher or a stretcher in a patient transport vehicle.

With ultrasound, we currently have an ultrasound coverage that is full-time for several hours a day. Prior to that, it was only two days a week; it was Tuesdays and Thursdays. What we don't have is actually even Monday to Friday coverage for ultrasounds all the time. We fought long and hard—it might have even been 10 years ago now or 12 years ago—to even get a CT scanner available here at Ballina to even get it five days a week. The reason why we fought so long and hard is because the cost that we could see for those ambulance transfers was exponential. Not only was there a cost incurred obviously either to the patient or to Health if they were transported here but, at the early part of us gathering data, it was $600 just for a transfer to get them to the base.

As I understand it, having spoken to my colleagues at Lismore, when they get to the base hospital at Lismore what happens is that they'll arrive and they'll need that CT. Maybe CT is occupied, maybe CT is having to be called in. That could all happen while the patient is still on an ambulance stretcher, and they can face many hours of delay to get the scan in the first place. And then, to free-up that ambulance stretcher, that person then would be allocated a bed in emergency. If all is well—and perhaps let's say they've got to return back to an aged care facility—they would then wait there for a vehicle to transport them back, whether that's patient transport or an ambulance, and so it goes on. So somebody's journey, in a realistic way, could be anywhere from 10 to 24 hours to have a screening that they didn't have a head injury after a fall, or that their abdominal pain was simply constipation and not an abdominal sepsis. If we had CT scans after hours here, if we had ultrasound available to us after hours or certainly Saturdays and Sundays until five o'clock, I believe that our transfers over the weekend would be reduced significantly.

Ms CATE FAEHRMANN: Firstly, just a quick question to you, Ms Melchior. Are you worried about any blowback from NSW Health in terms of appearing at this inquiry today? Did you get permission from NSW Health or the union? How does that work?

SUZANNE MELCHIOR: I sought permission from the union and I also discussed this with my manager. But I'm actually in a position where it's an issue that needs to be spoken about, and I don't believe that even the people on the ground believe that it's something that shouldn't be spoken about. So I'll wait to see what ramifications come out of this. I'm more than happy to be a spokesperson for Health and for how it's deteriorating generally, but also for this particular issue where I just see my own work colleagues and the other professionals that we lean heavily on and we work closely with our ambulance service, there's a complacency. People are so worn out that people aren't willing to talk, purely because they don't believe that any change can come. So I am here because I actually believe that there is change. I believe we can improve systems.

Ms CATE FAEHRMANN: Thank you. With individual nurses, I do know that it's very difficult to speak out and often they can't, specifically because NSW Health won't let them. So thank you so much for appearing. I wanted to ask a general question about mental health beds and mental health patients not having access to beds. I will go to Dr Velovski first and then to you, Ms Melchior, because I assume that particularly in the Northern Rivers post-floods the demand is more acute than ever. Dr Velovski, how much of an issue is the lack of inpatient beds for mental health patients? How much of an issue is that in terms of what's happening in our emergency departments in rural and regional New South Wales?

SUE VELOVSKI: A number of our rural and regional colleagues tell us the same story, just the geography is different—too many patients with mental health issues, some of whom could have been looked after in the community. Since COVID, the ability to get to see mental health physicians, clinicians, psychologists, psychiatrists, certainly in our area, pre-COVID and pre-floods what was considered non-urgent mental health care

people were waiting 16 to 18 weeks; that's increased. Some people have given up. A lot of that mental health was also provided by our GPs in the area. Again, the lack of access to GPs post-floods has meant that, as Suzanne will tell you, there are multiple patients in the emergency department waiting to be assessed by our psychiatric colleagues. A number of patients on every shift, quite a number of days, will self-harm or are angry and harming our staff. So it's dangerous for our staff and dangerous for the patient, and they're waiting extraordinary hours to be seen in a very crowded facility.

All of these little systems that have been broken contribute to increased complications, increased morbidity. You would know, as well, every hour spent in an emergency department increases morbidity and mortality. The other thing is, my rural and regional colleagues in psychiatry are quite anxious. It is almost like the only people that are able to be seen in a NSW Health psychiatric facility are the patients that would normally, 10 years ago, have been admitted to psych ICU. Everyone else has to be discharged to a community where, now, after natural disasters, people are still living in tents. There are students and families living in motorhomes who are doing their HSC. I have quite a number of cancer patients that will recover from their bowel and breast surgery in tents, in the wet. That's just unsustainable for the community and it impacts on everyone—everyone who is trying to just stay afloat, for want of a better word, and also everyone who is trying to prevent any further complications and working in the best interests of safety and quality for our patients, in spite of what's not happening for us.

Ms CATE FAEHRMANN: Is it okay to jump to Ms Melchior now, Chair, as well?

The CHAIR: Yes.

Ms CATE FAEHRMANN: Sorry, my time has officially run out, but I just wanted to also see if Ms Melchior—

SUZANNE MELCHIOR: I just want to fully endorse what Dr Velovski said, and just add that one of the other observations—we talk about centralising services to base hospitals, one of the things that has happened with mental health services in this district in the time that I have worked here, and I know that it's spread across other area health services, is when I first started here we had a community hub for mental healthcare needs that was based out of our town community health centre. If we had a mental health patient present, we were able to resource locally and they could be here within an hour to two hours—very similar to how we refer to a social worker or a physio and make an assessment in the emergency department. Now fast forward, obviously, I believe that funding was cut significantly from our mental health community services and we saw centralising of a majority of community health facilities, but particularly mental health. We've had to reintroduce MHEC-RAP, which is the impersonal mental health assessment over Zoom, which—as you experienced with me getting reception here in a public health system—sometimes it would freeze, and a person who was genuinely mentally unwell would not cope even with that process of admission.

I agree, again, with Sue that only the worst presentations, who are your ICU-level mental health, would get the care and have the treatments that are appropriate. In my memory, the longest time that I've had a mental health patient waiting for a mental health bed in this department here was 32.5 hours. Now that's nothing compared to some patients that I've heard of at the base hospital who actually waited five days, and in actual fact were discharged from the emergency department. They never received appropriate mental health care or inpatient care because of the lack of beds. At the moment, I do understand there is a lack of staffing to suitably care for those people. So it is of grave concern. I don't see it getting easier, particularly in light of our community's and our district's journey at the moment.

SUE VELOVSKI: From what Suzanne also said, it's not just looking after our patients but we have a duty of care to look after our staff. There are some really brilliant nursing staff in all aspects—from emergency, psychiatry, the wards. But it was interesting to hear—and I wrote it down—Suzanne said, "I prefer to be on night shift to stay away from management". There is this perception that—and not just in our areas, but across the whole of rural and regional New South Wales—there are all these layers of people who are supposed to help us help our patients and make us a better version of who we are, but you have comments like that: "We'd prefer to be away from management and just get on with the job of nursing and doctoring", because there is so much—

The Hon. WES FANG: Could I just confirm—my interpretation of that comment was that it was around the tasks of management as opposed to the people themselves. Can the witness perhaps provide some insight into that?

SUZANNE MELCHIOR: Yes, sure. I can elaborate on that. You are right, it can be taken in two ways, and neither of you are actually incorrect. I have previously been in an acting nurse unit manager role in this emergency department, as well as after-hours manager roles, as well as clinical educator. Some of my comment is actually in reference that if I'm away from the floor then in actual fact, because I've been here for 20 years in

this one department, a lot of people will come to me asking for me to make decision processes which are actually the current manager's processes to decide on, or ask me to contribute to wider management decisions that are outside of this hospital—but, again, that is not my scope. There has been an active decision for myself to remove myself physically from the daily decision-making so that I am not influencing and/or getting burdened with tasks that are actually not my job description or my role. Does that add a bit of clarification?

The CHAIR: Yes, it does. You have both been very generous with your time. We have gone over—in fact, we have gone well over, which is not your fault because you've got so much valuable information and detail to pass on, but we will need to draw it to a close now. I thank you both very much. It has been most insightful, not just to have that opportunity to read your contributions through your submissions but, for me, anyway, in particular, today have that one-on-one engagement and hear from you directly on so many matters that are going on. Thank you for the wonderful work you do for and on behalf of the communities you represent in northern New South Wales. They have been through and continue to go through a most difficult time and they are certainly not out of the woods yet. Thank you for the great work you do. We will move now to our final session.

SUE VELOVSKI: Sorry, I know you're running behind. Thank you for your time today. On behalf of the Rural Doctors' Association of NSW and all of our amazing nursing staff and doctors who come in and out every day, thank you for your inquiry into health outcomes and access to health and hospital services over the past years. We note as an organisation that this ambulance ramping inquiry has similar concerns or challenges to what we discussed in the inquiry a few years ago. It is also very interesting—and I am sure my nursing colleagues like Suzanne would agree—that there were 40 of 44 recommendations accepted, and the ones about workplace culture, recommendations 40-44, were noted.

I note the justifications by the Government; we note that as an organisation. But—and you would know this already—it is very difficult in rural and regional Australia to be confident to step up as a nurse and speak out, but we do it because we couldn't live with ourselves otherwise as doctors and nursing staff. If there is anything to come out of those recommendations besides being noted and supported, I think they would also be of value to consider in the ramping inquiry. There are lots of other organisations that use human factors and science to resolve these issues. I would like you all to consider that seriously for our patients in New South Wales.

SUZANNE MELCHIOR: Thank you, Sue.

The CHAIR: Thanks, Doctor. We continue to press the Government and invite them to review that position and perhaps move from that position of note to support. We will wait and see. Thank you very much.

(The witnesses withdrew.)

CORRECTED

Dr JACQUELINE HUBER, Fellow, Royal Australian and New Zealand College of Psychiatrists, before the Committee via videoconference, affirmed and examined

Mr CHRISTOPHER STONE, Policy and Government Relations Manager, Suicide Prevention Australia, affirmed and examined

Miss CHARLOTTE GONZAGA, Lived Experience Speaker, Batyr, sworn and examined

The CHAIR: Thank you very much, all of you, for making yourselves available today. We are at the end of what has been a very full day, but we are all looking forward to hearing the evidence from yourselves. Just to confirm, we have received your respective submissions. Mr Stone and Miss Gonzaga, your submission is submission No. 18 to the inquiry. It has been processed, uploaded to the inquiry webpage and stands as evidence to the inquiry, which is great. Dr Huber, the Royal Australian and New Zealand College of Psychiatrists' submission has been received. Thank you very much. It stands as submission No. 14 to the inquiry. It has been processed, uploaded and stands as evidence to the inquiry, so that is great.

You can take the submissions as read, so when I invite you to make an opening statement shortly you don't need to read from the submissions per se, but perhaps spend a few minutes opening up the areas in particular you would like to draw to our attention. If you are agreeable, after that we will share the questioning around. We have representatives on the Committee from the Opposition, Government and crossbench. We will proceed that way. Dr Huber, would you like to make an opening statement?

JACQUELINE HUBER: The college would like to convey that we view the ambulance ramping problem as a symptom of an all-of-system problem and something that we have noted that many of the submissions have brought up. So we regard the solution as being an all-of-system solution. In particular, we would like to draw your attention to what we perceive to be a lack of resourcing in the areas of community mental health, inpatient mental health and crisis mental health, which, of course, reaches across all areas of mental health, with particular attention to child and adolescent psychiatry and also older person psychiatry.

The CHAIR: You may like to do one opening statement or share between yourselves. You're more than welcome to share if you wish. It's entirely up to you.

CHRISTOPHER STONE: We have just one opening statement. First of all, thank you for the opportunity to attend this hearing. I'd like to start by acknowledging that we're on Aboriginal land and pay my respect to Elders past, present and emerging. I'd also like to acknowledge the impacts of suicide and the importance of lived experience and the lives lost to suicide. I am the policy and government relations manager at Suicide Prevention Australia. We're the national peak body on suicide prevention. We have over 350 members across the country, including the largest and many of the smallest organisations working in suicide prevention. Collectively, this represents about 140,000 workers and volunteers across Australia. We exist to provide a clear, collective voice for suicide prevention. We work to inform through data and evidence and to influence systemic changes that drive down suicide rates.

Our interest in this inquiry stems from the fact that over 6,000 people each year attend emergency departments in New South Wales following a suicide attempt or self-harm. We've undertaken some work in this area, including a report focused on young people. The importance of this report derives from the fact that it comes from young people. It was young people who decided that we do the work in this area. It was young people who made it clear that although there are things we can do to improve emergency departments, what's needed are alternatives to emergency departments for young people in suicidal or mental health crisis.

For this reason, I'm joined by Charlotte Gonzaga, one of the 85 young people who provided input to our report. Charlie is a volunteer, a lived-experience speaker, with one of our member organisations, Batyr. Batyr trains their speakers to be able to share their stories of resilience in ways that are empowering and helpful to those young people who may be experiencing difficult times. Like many young people, Charlie has had the experience of being in crisis, attending an emergency department and not receiving the support that she needed.

I should note, in closing, that we don't intend any criticism of the hardworking staff at emergency departments. The problem is, mostly, that emergency departments are simply not the right place for many of those in suicidal crisis or mental health crisis. Charlie is here to provide firsthand experience of why we need alternatives to emergency departments. These alternatives will not only be better for young people in suicidal crisis; they would, by diverting young people from emergency departments, help address overcrowding. Charlie and I are happy to answer any questions that you have.

The CHAIR: Thank you, Mr Stone. Ms Gonzaga, thank you for coming along this afternoon. It is very generous to come along and share what might be some difficult memories that you experienced but through that,

and talking openly and publicly, help others become aware of challenges and hopefully seek assistance and obviate problems that might otherwise flow from that. We will commence our questions, which we will divide up amongst the groups around the table. We will start with the Government, which hasn't had a chance to go first today.

The Hon. WES FANG: I might direct my questions first to you, Mr Stone. In circumstances where there is somebody who is at risk of, say, self-harm or where there is suicidal ideation that is present in somebody and an ambulance is called, what's the impact on that person when they are perhaps being transported and then waiting to be seen at, say, an ED? Is there an anxiety issue that's created in them if they're not seen quickly or is there a worsening of symptoms? Is it something that can be managed by the ambulance staff or the ED staff at the time? What's the experience of somebody that's undergoing or experiencing those symptoms?

CHRISTOPHER STONE: In our research and consultation with people, we focused on the experiences in the emergency department. Yes, you're absolutely right that there are significant issues when they spend long periods in the emergency department. As to whether it can be managed, there are certainly things that can be done. Some of the issues that occur are the fact that emergency departments are often quite distressing places in general, and that exacerbates the existing mental health crisis. There were some suggestions from young people about making separate areas and places like that, but ultimately the issue really is that emergency departments are always going to be that sort of place and there needs to be alternatives to emergency departments. Charlie, did you want to speak to your experience in an emergency department in that regard?

CHARLOTTE GONZAGA: Yes. I think that's actually a great question. I think I can speak for a lot of other young people. There's no clear process that we're taught at schools or at workshops of what it's like to actually call an ambulance or wait in the ED. For me, spending five hours there while you're already in a mental health crisis, when you're already distressed, just makes it a lot worse, especially when you don't know what's going on, no-one is openly communicating to you and telling you about—or updating you at least. It kind of heightens your feeling. It's initially scary, I think, for the average person to call an ambulance or to enter the emergency department but how much more for someone dealing with a mental health crisis? For me, personally, it was terrifying. Five hours felt like a day.

The Hon. WES FANG: We've discussed quite a bit during this hearing today that we've got a number of States that do things differently. The Australasian College for Emergency Medicine said that, in their opinion, New South Wales is doing a lot of things a lot better than other States are. Do you know perhaps how some of the other States handle people who are in distress with mental health concerns at the time that an ambulance is called? How does that compare with New South Wales? Part B to that question would be—we've got some safe havens that have opened up. I've got one in Wagga. We've got some around the State—quite a few in regional areas. Do you see those as being part of a way of alleviating those concerns around waiting in an ambulance or an ED? Is it more of a safe haven for those people experiencing that distress?

CHRISTOPHER STONE: Yes, absolutely. The Safe Haven model is one of the models that we discuss in our report. It's part of a number of models that are run as alternatives to emergency departments. The issue is that coverage of emergency alternatives is far from universal and it often doesn't cover a 24-hour period. As well as that, there are certain groups who need specialised centres. What we're advocating for is youth-specific alternatives to emergency departments as well as general alternatives—universal coverage. I hope that answers your question.

The Hon. WES FANG: Yes, it does. Sorry, I'm trying to pull up some data as I'm talking to you about it. Ms Gonzaga, have you had an opportunity to see how the Safe Haven model operates? Can you perhaps provide some insight—as much as you feel comfortable with—as to how it might have made a difference to the experience that perhaps you and some other people who you may have engaged with might have experienced at that time?

CHARLOTTE GONZAGA: Unfortunately, I haven't had the chance to really look into it, outside of what's in the report or in the forums leading up to it. But I know that for, again, a lot of young people like myself, especially at the time, just the knowledge of these services and hotlines is not as available as you'd think it was. At the time when I was going through my mental health crisis, I had no idea about Lifeline even or Kids Helpline. A lot of young people would just think, "Oh my goodness, what am I going to do? I guess call an ambulance or get driven to the emergency department". I guess that's another barrier—the lack of access to these resources, as in even letting young people know about it. I never got these things at school.

A lot of the work we do at Batyr is raising awareness for places like Safe Haven or crisis lines. In a general sense, I had no idea about these at the time. But knowing about it would have definitely helped tremendously or if someone at the hospital, at the ED, would have told me that there are a few options for me, that would have alleviated a lot of anxiety and stress in the moment.

The Hon. WES FANG: Dr Huber, I want to turn to you for a little bit if you don't mind. We've heard a lot today from people who work in EDs—the College for Emergency Medicine, the Nurses and Midwives' Association, the HSU and the unions that represent paramedics—about what they see as the difficulties with ramping and what may assist in resolving some of those issues. But from your perspective and that of the College of Psychiatrists, I guess it will be slightly different. Whilst you have some engagement around the ED, I imagine that you won't necessarily see patients there; you'll perhaps see them in the wards or in practice outside. But they will have provided some insights to you as to how they felt at that time, whether it be in the acute setting in the hospital or afterwards in an outpatient setting. Will you provide to us some insights as to how you and the college might see those impacts for patients? What might New South Wales do that's good in that space? What could we learn from other jurisdictions—other States or even internationally—around the treatment of people who have a mental health concern at the time they present to an ED, whether it be through an ambulance presentation or through the actual ED itself?

JACQUELINE HUBER: I am an emergency psychiatrist. I work in an emergency department, on a crisis unit and in a toxicology unit, and I have access to and have discussed this issue with psychiatrists who work in emergency departments and in crisis units. I think New South Wales does do some things well. There's just an echo I'm having to—sorry if I get distracted.

The Hon. WES FANG: Apologies. We hear you perfectly, so there's no concern on our end.

JACQUELINE HUBER: There are hospitals in New South Wales that have piloted a model within the emergency department where there is an area of the emergency department staffed by mental health nurses and where there is a comprehensive liaison service that are psychiatrists and a psychiatry team that does comprehensive in-reach into an emergency department and has access to a crisis unit and, as I mentioned, a toxicology unit. A number of the hospitals in New South Wales are in the process of planning how to create such units as well. That is, I think, being done quite well.

I would like to mention SafeHavens in particular—which I think are just fantastic, wonderful and do a really great job but, as my colleagues just now mentioned, are not universally accessible and are generally not accessible 24 hours. I and the college, in fact, would advocate for both. We would suggest that emergency departments absolutely need to be staffed by people who have expertise in mental ill health and should provide environments that are tailored to people who present in a crisis of mental ill health. But that ambulance ramping can't be regarded solely as a diagnosis but rather, as I mentioned, a symptom of a whole-of-system problem—which is why we're strongly advocating for increased resources in the community in order to try and catch crises of mental ill health before they get to the point that they need to present to ED, in the knowledge that that is not always possible.

The Hon. WES FANG: Thank you very much for that very comprehensive answer.

The Hon. EMMA HURST: Thank you all for attending this afternoon. Ms Gonzaga, thank you for coming today and speaking with us. This inquiry will make a report with recommendations to the Government, and I want to hear a little bit more from you. I know you've talked about a lack of knowledge of services amongst young people, but I want to get some more information about what you feel this Committee really needs to know to help us form some of those recommendations that will really assist people when they're needing that help.

CHARLOTTE GONZAGA: Thank you, Deputy Chair. I think the biggest thing that I'm coming here with today is the fact that the emergency department is just not an ideal place for young people going through a mental health crisis. Like Dr Huber said, it's amazing that a lot of hospitals now have a staff specifically for mental health. But just trying to think back to what it was like for me as an 18-year-old, it's scary enough to try to get myself to, say, the ED. I couldn't even call myself an ambulance, just because the process of calling an ambulance was something so foreign to me. It doesn't get taught in schools; you don't really know what to expect. When you're going through a crisis, it's not really something you can focus on.

But even in the ED, my experience in the ED was I remember feeling quite dismissed. It would have been so helpful if I had someone at the time really talk me through what was happening, or who could have directed me to somewhere like a Safe Haven or let me know of other services, or who even just had updated me through what was going on while I was waiting. I think it is just a very daunting place for a young person in a crisis to be in. I think it's daunting for the average person just going to the ED, but even more so being a teenager, an adolescent, especially if you're on your own if, say, you don't want your family involved or things like that. There's a lot of stigma around mental health still, so just that environment doesn't foster that safe, supportive thing that you're seeking out when you're going through a mental health crisis.

The Hon. EMMA HURST: Dr Huber, based on that answer, when somebody—and particularly a young person—presents with a serious mental health concern after hours, what options, if any, do they have right now other than to access an emergency department?

JACQUELINE HUBER: That's a super important question, because they don't always have a Safe Haven to present to. In terms of the public health system, they should be able to access something called a crisis team, which should be available at every hospital and traditionally used to be able to offer home visits. They used to be able to go to a person's house and give them the medication that they needed, sometimes up to twice a day. They used to be able to offer very regular community appointments with a psychiatry registrar or some sort of other psychiatry clinician, sometimes a psychiatrist. Over the years, it's our experience that the resourcing for those community teams has been severely diminished, which means that that type of offering is no longer available. So rather than having very regular outpatient appointments with a crisis team and being visited at home regularly in order that they can avoid a crisis of mental ill health and can avoid coming to the ED, they have to come to ED. Those resources that used to be available seem no longer to be available.

The Hon. EMMA HURST: You also noted in your submission that the length of stay and wait times were disproportionately longer for people who were presenting with mental health concerns. For the benefit of the Committee, can you provide some insight into why they are longer?

JACQUELINE HUBER: Yes, ACEM has put out a number of reports reporting that data, so that's partially the data that we're using to make that comment. The question of why is complicated. We hypothesise that it may have to do with the fact that mental health beds have severely diminished. You may notice there's a table in our submission with a description with numbers of how many people have been presenting to emergency departments with mental ill health complaints and the number of hospital beds that have changed over the years. The numbers that I have here are that over five years the number of ED presentations has gone up by 15 per cent and the number of inpatient beds has gone up by 5 per cent.

If you have more people sitting in the ED waiting for an inpatient bed, they will be sitting with the ambulance for longer and longer and longer until those ED beds become freed up, because people are going into inpatient beds, and finally the person will come into the emergency department. So we hypothesise that that has something to do with it. Also, it's worth noting that mental health assessments take longer than assessments for other medical problems because we do take a thorough psychosocial assessment, because psychosocial distress is a significant and prominent factor for people presenting in a crisis of mental ill health. We feel that there are a number of solutions to that, all of them system-based solutions, including increasing beds but also increasing community team numbers and, of course, resourcing emergency departments with subspecialist mental health clinicians.

Ms CATE FAEHRMANN: Firstly, thank you all for coming today. It's really important to get your perspectives. I wanted to turn to the safe havens. Can you give us an idea of how many of these are in operation throughout New South Wales? Are they within LHDs? Are there quite a few within each LHD right across New South Wales? Are they more on a trial basis? How do people know about them and access them? I might go to you first, Dr Huber, about that.

JACQUELINE HUBER: The safe havens, as far as I understand, were funded as part of the Towards Zero Suicides funding injection. I believe every LHD was expected to create a safe haven, but the template for the safe haven didn't necessarily have to be the same across LHDs. So safe havens are aimed at a slightly different population per LHD. They're a non-clinical space, generally mostly staffed by peer workers. They are really extraordinary individuals, by the way—these peer workers. As far as I understand, in each LHD, the word gets out in a different way. I can tell you that in our LHD, we tell every person who comes through the door that we have a safe haven and how wonderful they are. Our peer workers happen to come into our ED to speak to people who come through the door and sometimes take them to the safe haven from the ED to show them the space, and also from our inpatient ward, and invite them to attend. Also, if people call our local crisis team, we tell them about our safe haven, the hours it's open and what's available. We also have something called a Suicide Prevention Outreach Team. Many LHDs also have these—but not all—which, again, consist of peer workers who can offer limited community support for people who present with suicidal thoughts.

Ms CATE FAEHRMANN: Thank you, Dr Huber. Sorry, which LHD are you working in again?

JACQUELINE HUBER: St Vincent's. But I'll just remind you, I'm not representing St Vincent's; I'm representing the college of psychiatrists.

Ms CATE FAEHRMANN: Yes. You said your LHD. I couldn't remember whether you'd stated that. Do either of you have any thoughts as well about safe havens? We've been hearing where they are. Clearly, there

seems to be a need for more of them and obviously your members have found them useful and valuable. They're clearly something that you would encourage the Government to fund more of?

CHRISTOPHER STONE: Yes. The evidence is that they're very good. As I say, the issue is that they aren't necessarily, in their current formats, designed for young people, and that can be an issue. They are not always available 24/7. And the coverage—LHDs can cover a very large geographical area. Particularly for someone who doesn't have their own transport, access issues are significant. I would describe the coverage, despite the amount of funds that have been injected into it so far, as still more sporadic. Can I also just respond to one of the things about making sure that the safe havens are accessible? And this relates to the earlier question from the Deputy Chair. The key thing you need to know about is co-design. Charlie has made a number of key points about what these services need to have and this is the thing: Young people and those with lived experience of all ages know what's needed to make sure that these are accessible. They know where it needs to be located, how it needs to be set up and what processes need to be there.

Ms CATE FAEHRMANN: Great. That's excellent. Ms Gonzaga, I just wanted to ask you, with your experience within the ED, would it have made a difference if there was a mental health nurse? It sounds like there weren't any mental health trained physicians or health professionals there at the time you presented. Is that correct?

CHARLOTTE GONZAGA: Yes, that's correct. And absolutely it would have made a difference. In my experience, when I was there in crisis, like most days I'm assuming in the emergency department, it was just a lot of scrambling and a lot of moving about. And at the time they didn't have any mental health nurses or no-one at least that was brought to my attention nor was I brought to their attention. So I was left just waiting for five, almost six, hours with no update on what was going on. It would have absolutely made a world of difference if, even for just five minutes at the start, someone was there to sit with me and talk me through what was going on or to really just check in with me. I know a lot of things arise like ramping, but in the moment, it was just a really scary, traumatic experience.

The Hon. ROSE JACKSON: Thank you so much for coming along. It is incredibly important. We received evidence earlier today that, in relation to the pressures on emergency departments, actually young people presenting with mental health issues was the fastest growing category. So this is an incredibly important part of this conversation. Ms Gonzaga, I wanted to ask you if you wouldn't mind just stepping us through your story. You've mentioned a couple of times bits and pieces of it. You didn't even know how to call an ambulance. You mentioned waiting in the emergency department for a number of hours. I just wanted you to step us through what happened to you, if you don't mind. Because I do think sharing those stories and that lived experience is a really important part of us getting away from some of the statistics and the clinical terminology, and understanding what the journey is like for a real person—a real member of our community—and to reflect on how we can do it better.

CHARLOTTE GONZAGA: Thank you so much. I am more than happy to. My name is Charlie Gonzaga—Charlotte, but you can call me Charlie. I'm currently 22 years old but my lived experience story starts when I was 18 in my HSC year—year 12. This was the first time I presented with really severe symptoms of anxiety and depression. I eventually got thankfully diagnosed at a community service—a headspace—which I found very helpful. But in my first bouts of panic attacks, I remember being at an event outside of school celebrating our trials, and that was the first time I'd experienced a panic attack. As a young person who wasn't educated or aware at the time of what a panic attack may feel like, it's terrifying. A lot of people say you feel like you may die. It's the walls caving in on you; it's the tightness in the chest; it's the wanting to speak but nothing coming out. It's confusing having to feel these things for the first time, which is why my friends and I decided, "We don't know how to call an ambulance. What do we do? Let's call an Uber to the nearest hospital." That was kind of my first experience with a panic attack and going through terrifying scenarios and having to be left there just because of spacing issues. So I was alone for a while.

The Hon. ROSE JACKSON: Which hospital did you go to, if you don't mind me asking?

CHARLOTTE GONZAGA: It was the one in Randwick—Prince of Wales, I believe.

The Hon. ROSE JACKSON: So your friends went with you, but then there was no space for them.

CHARLOTTE GONZAGA: Yes.

The Hon. ROSE JACKSON: So you're on your own.

CHARLOTTE GONZAGA: Yes. I was there for a few hours and just decided—eventually I was seen and, because I wasn't on medication at the time or diagnosed at the time, I was just told, "Maybe see a GP in the morning. Get a mental health plan. You get 10 sessions." This was at the time—2018. And then I kind of just had to go back to my party.

The Hon. ROSE JACKSON: Right. The reality is that that mental health episode passed on its own with you waiting there. It was not a clinical intervention that resolved that particular crisis for you. It was you sitting in an ED.

CHARLOTTE GONZAGA: Yes. It was me sitting in ED, still in my panic attack. I was really grateful that my stepfather, after that, told me about Lifeline and these kind of resources. But, even when I was in ED, waiting, no-one raised that with me or made it known that these were things available to me, even while I'm waiting. It was a busy night. I remember lots of people. My friends couldn't even stay. But it wasn't until, luckily, after that—I was really grateful—that one of my teachers actually recommended me to more community-based services, like headspace or our local youth services, that I was able to go to and get the diagnoses and everything.

But the whole experience in the ED—five hours seems like a short time for a lot of people. But, when you're going through—I remember, I think, earlier it was mentioned that some people wait 32 hours or five days. But, for a young person, for a lot of us, it's first time in the ED. It's a terrifying experience if you're left all alone with no-one telling you what to expect. There are no clear processes. It would've been so helpful at the time to have someone to support me with both medical and compassionate care. It would've been so helpful to at least be told, "Hey, there's this going on at the moment. It might be this much more time to see you" or "You can go", "The toilets are at the back", things like that, or just letting me know that there are mental health nurses available or not available or just telling me my options there and then. I think it would've been a lot more helpful if someone had said, "Because you're not diagnosed yet, you're not on medication, here's what you can do now to get past the anxiety attack, the panic attack. Then, when you can, go to the GP", so on and so forth, instead of leaving me anxiously waiting for five hours.

The Hon. ROSE JACKSON: Obviously, it's incredibly important that you had the support of your friends and your family and a teacher that enabled you to get through that and be such a powerful advocate here today. I know you're involved in Batyr.

CHARLOTTE GONZAGA: Yes.

The Hon. ROSE JACKSON: Just drawing on those other experiences, you as an advocate, you managed to process what was, obviously, a very scary experience of someone who's barely an adult, almost a child. How can it go bad? How can experiences like that for a young person having a mental health episode, spending five hours alone, scared, disoriented in an ED, seriously exacerbate their mental health situation? Have you heard stories about how that can lead to a pretty serious deterioration in someone's situation?

CHARLOTTE GONZAGA: Most definitely. I've had close friends of mine in high school who have been in situations like that and have, unfortunately, just acted on those self-harm ideations. I was more fortunate to be—the way my panic presents was just to sit there and freeze for five hours. But I, unfortunately, know—I had friends in high school who had to go through a similar thing, be it not at the ED, be it just at the children's or the young people's psychiatric units, where they'd had to wait or were not given adequate information on what was going on or have just been left in the dark. Unfortunately, what happens when you're alone for how many hours or how many days—a lot of people, unfortunately, do act on those ideations that they go to the hospital for help with.

The Hon. ROSE JACKSON: They go to the hospital. They're waiting. There's no-one helping them. And that can manifest in terms of further feelings of isolation and wanting to act out.

CHARLOTTE GONZAGA: A hundred per cent. For me personally, I remember even saying to myself, "I'll just go home now because I don't want to bother those people." There's a lot of self-stigma around mental health that we know of. When you're a young person, you go through all these feelings, like "I should just leave. There's someone probably more important who needs more help than me, so I'll just leave"—or someone who won't know what to do, like me at the time. But, yes, unfortunately, for a lot of young people as well, waiting just makes the feelings a lot worse. Some people would, unfortunately, rather just go by themselves and act on these ideations than wait five, six hours, five days, 32 hours.

The Hon. ROSE JACKSON: You mentioned that stigma. I just want to ask about that as well because I think—you've already mentioned lack of education and lack of information. People often think, "Emergency departments—that's for when you have a car crash. That's for when you break your arm." So there perhaps can be stigma about people that are having a mental health episode, even though, as you say, for that person, it's incredibly scary and traumatising but even still saying, "I'm not sure if this is where I should be" and questioning presenting for help. Is part of the problem the stigma and not understanding where to go for mental health care?

CHARLOTTE GONZAGA: Most definitely. Stigma still, unfortunately, remains one of the biggest barriers to young people, especially, accessing mental health—most definitely. The self-stigma as well—even me at the time. I felt quite embarrassed, having to have my friends—they didn't know what to do. I felt like I was

being a party pooper. But now, obviously, in retrospect, you can look back and laugh and say that's silly. But, unfortunately, that is the reality for a lot of young people, not just in Australia but all over the world.

The Hon. ROSE JACKSON: That's the importance of that dedicated space, because young people—

CHARLOTTE GONZAGA: Yes.

The Hon. ROSE JACKSON: Creating the space, then educating young people about it. But the first step is creating it, is having it there so that they know, "There is a special place where I can go." As we've said, this is the fastest growing group. This is not a small problem. This is actually becoming a profound problem. So having a dedicated response—that's the key part of your advocacy today, is it?

CHARLOTTE GONZAGA: Yes, most definitely. It would've made a world of difference if I was able to walk in, let them know what I was going through and be brought to someone who would have been able to sit with me and talk me through what was going on and make me feel that I was welcome and supported.

The CHAIR: We could probably go on, but you've been very generous, all of you, with your time this afternoon. It's been very enlightening for us. The submissions were good, but I don't think anything quite beats having a face-to-face opportunity to engage and go back and forth with the questioning. Mr Stone and particularly Ms Gonzaga, thank you very much. Obviously, we can look at that and say, "Come along", and says it and it's pretty straightforward. But, clearly, it wasn't. It was a great challenge at the time. You've come through it, but your advocacy and your ability to explain and be empathetic and just talk naturally about the experience, I'm sure, resonates with a lot of young people and, no doubt, will give some assistance to numbers you will not even understand, over time. So thank you very much.

CHARLOTTE GONZAGA: Thank you so much.

The CHAIR: Doctor, thank you very much. We appreciate you this afternoon on behalf of the organisation, the college, coming along and providing us also with the opportunity to ask questions. There may well be questions that arise from members reading *Hansard* after the hearing's completed. If you're agreeable, we'll, through the secretariat, liaise back with you with what are called supplementary questions and then liaise over the return of answers to those. Once again, thank you all very much. For those who've joined us on the Net, that brings us to the conclusion of today's hearing.

(The witnesses withdrew.)

The Committee adjourned at 16:58.