REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Room 814-815, Parliament House, Sydney on Friday 7 October 2022

The Committee met at 09:30.

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Mark Buttigieg
Ms Cate Faehrmann
The Hon. Scott Farlow
The Hon. Emma Hurst
The Hon. Aileen MacDonald

PRESENT VIA VIDEOCONFERENCE

The Hon. Lou Amato

* 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.

The CHAIR: Welcome to the second hearing of the Portfolio Committee No. 2 inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales. 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 acknowledge the diversity of the Aboriginal peoples and their ongoing cultures and connection to the lands and waters across New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people who may be joining us today in person or over the internet.

Today we are hearing from a number of stakeholders, including peak medical bodies and organisations, as well as emergency medicine staff and specialists. We will also be hearing from NSW Health and NSW Ambulance later this afternoon. While we have many witnesses with us in person, some will be appearing via videoconference today. I thank everyone, whether in person or through videoconferencing, for making the time to give evidence today. It is an important inquiry and we appreciate that you are all very busy individuals.

Before we commence, I will make some brief comments about procedures. Today's hearing is being broadcast live via the Parliament's website and 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 who are with us or may be joining us later 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. Therefore, I urge witnesses to be careful about comments they may make to the media or to others after they complete their 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 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 the question on notice. Written answers to questions taken on notice are to be provided within 21 days. 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 microphones. As we have a number of witnesses in person and via videoconference it is helpful to identify who the questions are directed to and, when answering, whose question is responded to. 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 tele-coil receivers. Finally, would everyone please turn their mobile phones to silent for the duration of the hearing.

Dr MICHAEL BONNING, President, Australian Medical Association NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our first witness. Thank you for joining us, Dr Bonning. We know that you are very busy. We will offer you the opportunity to make an opening statement and then move to questioning. I confirm, and we are grateful for having received it, that the Australian Medical Association NSW has made a submission. It has been processed by the Committee secretariat and is submission No. 33. It has been uploaded to the inquiry webpage and stands as evidence to this inquiry, which we will deliberate over in the preparation of our report and our recommendations. Of course, your oral evidence today will complement what is a very helpful and very useful submission. We thank you for that. I invite you, if you would like to do so, to make an opening statement. Please take it as read that Committee members have copies of the submission here and have read it, so there is no need to quote slabs out of it. We do have the material in front of us.

MICHAEL BONNING: Thank you, Chair. We see ambulance ramping and access block as a consequence of issues related to the overall functioning of the healthcare system—demand, supply and funding for healthcare services—constraints on which existed before the pandemic and have been exacerbated in the last three years. We are seeing an increase in demand through our members, but also through working with the hospital system, through a combination of aging population and a growing prevalence of chronic disease, which is exceeding supply in terms of both number of beds and having the right staff available to serve those beds, including in the emergency department and also in inpatient wards.

Barriers to access to primary care, particularly in regional, rural and remote areas, are causing downstream effects on emergency departments, and we know that exit block and the passageway of patients through hospitals and admitted patients awaiting placement in aged care or NDIS-funded facilities also contribute. What we see is that while the pandemic has exacerbated issues, the pressure on the New South Wales healthcare system has increased in the last decade and those effects have been seen through regular reporting of BHI data by NSW Health but also demonstrated through the actions and research of many of the professional bodies, including the AMA, the College for Emergency Medicine and many other healthcare bodies.

We see doctors, nurses and other healthcare workers are working far harder, and that the system is being maintained by extraordinary efforts, including over the last 2½ years, by healthcare workers in light of the fact that funding and support is not yet reaching the levels required to maintain adequate performance. What we see is that one in 10 patients left the emergency department, most recently, without or before completing treatment, from BHI data, and an increase of more than two-thirds compared with pre-pandemic figures. And we know that only 62.8 per cent of patients had their treatment start on time.

We know that while there are numerous horror stories arising out of unacceptable waiting times, it is the mundane nature of many waiting times that actually contribute to poorer patient outcomes, and we know that affects the way in which patients see and accept their treatment, and also the way in which hospital staff are able to provide that treatment because they are often fighting a catch-up game when treatment has not been started at a clinically appropriate time. I will leave my opening statement there and hopefully expand on things throughout the rest of the questions from the Committee. Thank you, Chair.

The CHAIR: That's very good. Thank you, Dr Bonning. I might open with the questioning and share it with my colleague the Hon. Mark Buttigieg. Perhaps I might just draw on this particular point that you made in your opening statement and ask you to elucidate a bit further. You made some comment specifically about exit block and tied that into matters to do with individuals who have entered the—I will use the word "generic system" through aged care or through the NDIS. I'm wondering if you could elucidate on an explanation of the matter of exit block and your particular observations about the dimension or size of that as a problem or an issue to be dealt with.

MICHAEL BONNING: Sure. We know that across Australia there are 1,400 patients who are trying to re-enter the NDIS system from hospitals, who are waiting on average 160 days to be discharged from the hospital sector. That was reported earlier this year. What we know is that those patients who we struggle to get out from the hospital are a function of their needs—so their need to set up services for them, whether it be in the disability insurance scheme and their providers or whether it needs to be access to aged-care beds. We note that the growth of our population over the age of 65 has been one of the significant contributing factors to both what is needed for beds outside of hospitals—so aged-care places—as well as beds inside hospitals, which is people with chronic diseases who need to be managed and then return home.

We know that this contributes a significant percentage—probably in low single digits—to our ability to manage exit and triage patients through the hospital. When we talk about managing the hospital, we are not trying or I don't think anyone is asking for outcomes to be that the hospital runs at 50 per cent capacity. We know—this

is from our learned colleagues at the College for Emergency Medicine—that, in fact, a target of 90 per cent hospital occupancy allows for a reasonable surge capacity to manage unexpected changes but also to allow for the capacity to move patients through elective surgery and to allow rapid access to hospital should someone deteriorate in the community. That dynamic is best supported by managing patients out and through the system, which involves integration and engagement with the NDIS and aged-care sector as well.

The CHAIR: Thank you for that answer. Just following on from that, I would be very keen to hear the association's opinion about what we understand but have observed and seen, which appears to be demonstrated by the figures, that the reduction in the availability of beds in New South Wales per 1,000 people, particularly over the age of 65—so we're dealing with the older, senior cohort—is having quite an impact. You made the point of the impact in your first answer; I'm pressing you further about the reduction specifically in the availability of beds per 1,000 people for that older cohort—that that actually is having quite an impact.

MICHAEL BONNING: What we see is that that availability of beds per 1,000 people aged 65 years and over has halved from the early 1990s to now.

The CHAIR: Sorry, Doctor. That's the number of beds?

MICHAEL BONNING: Yes, number of beds per 1,000 population aged 65 or over.

The CHAIR: The cohort, yes.

MICHAEL BONNING: When we see that group, we know that the group aged 65 and over is increasing. We've done wonders with modern medicine to improve people's quality of life and longevity. We know, however, that more and more people live with chronic diseases, which affects their ability to live healthy, longer lives—many of which also then, with exacerbations, end up in hospital. That population aged 65 years and over is 17.2 per cent of the New South Wales population, and we know that they make up 43.5 per cent of all admissions and 53.2 per cent of admitted bed days in New South Wales. That group is and has always been over-represented with regard to the use of hospital services. That is a function of aging. We cannot change that, but what we need to change is the way in which we think about chronic disease management within the spectrum of the hospital system and not just primary care.

While primary care is a significant and important part of the answer to that question of how do you manage the people in the community who are aged 65—in fact, anyone with a chronic disease—we also need to think about how the hospital, through rapid access to specialist outpatient clinics, is able to manage and plan the care of individuals to avoid unnecessary or unplanned hospitalisation, which is when we have more of a struggle with returning the person to health in a way that means they can move back into the community. While the bed days, Chair, are very important and the accessibility of those beds are very important for people aged over 65, it is also the systems that sit around it to prevent unplanned hospitalisation that can make the biggest impact on changing the way in which people present to hospital and how we manage them.

The CHAIR: Thank you, Doctor. That was a very comprehensive answer.

The Hon. MARK BUTTIGIEG: Doctor, I want to tease out that theme a bit. Reading the submissions, one of the consistent themes that seems to come out is the necessity of looking at it from a holistic point of view in terms of demand and supply about what are those factors outside the hospital that are creating the demand. This particular issue you have zeroed in on of the aging population, obviously that's a function of a society evolving over time to a point where people are living longer because of better medical care, better diets, better living and whatnot. On top of that, you've got people in the disability sector as well. Is part of this problem, in essence, that we are, in a budgetary sense, cost-shifting from the Federal sector to the State sector? In other words, because aged care and NDIS are not adequately funded and administered, perhaps, to the degree that would be ideal, then the public hospital system is simply taking up that excess load, which is then affecting occupancies of beds and then affecting the ramping. Is that too simplistic or is that an accurate assessment?

MICHAEL BONNING: There has been a long-term, essentially, essence of cost-shifting between Federal and States and Territories. It's written into the hospital funding agreements, where the Commonwealth Government contributes 45 per cent of the cost of public hospital services, and States and Territories fund the remaining 55 per cent. I think even at our starting point before we get to the NDIS and aged care, we see that States are the majority contributors to fund the services that are required for populations in each State. When States try to increase and catch up on the care that needs to be provided—we hear significant discussion of elective surgery waiting times and other access issues in hospitals—we know that there are annual funding growth caps of 6.5 per cent compared to the previous year, inclusive of health inflation, which is a disincentive for States to actively go after providing more care because, beyond a 6.5 per cent increase, they will be the ones paying for all of the care themselves rather than in a measured or a shared model.

When it comes to services outside of the hospital, we see it through multiple lenses. It is before the hospital, primary care services, and the accessibility of primary care services are a significant contributor to how people's health is managed prior to any hospitalisation. We also know that with the long-term [audio malfunction] and under-indexation of the rebate in primary care—the Medicare benefits schedule—we see fewer medical graduates going into general practice. It's now at 13.8 per cent of our graduates entering primary care. We know that that is actually the highly efficient and cost-effective place to manage many of these conditions. Hospitals are fantastic for high-quality and high-acuity care but much of the management of chronic disease, which is what our community now faces as its tsunami of care requirements, is in fact best managed in the community, near where the patient lives and by someone who has a longitudinal relationship with them.

When we move beyond and outside the hospital walls, with the NDIS and aged-care system, what we see is a disconnect between those systems and regular access to the health services that are required. If I posit that many of the people who enter and exit our hospital system from aged-care and disability services could be better managed if we could provide services closer to where they are, whether it's into their nursing home, through geriatric care or geriatricians, through rehab care, through better general practice access, and the same goes for the complex needs of those people with disabilities. We would likely see that many of those patients were less likely to end up in our hospital emergency departments and therefore start an episode of care in the hospital that is drawn out and not particularly productive for their individual lives, and which also is difficult to manage. Hospitals are generally not set up for the long-term management of the frail elderly. In actual fact, you want people who have complex needs such as that to be in their own home or in an environment that is familiar to them. That's better for their long-term care and health. It is multifactorial but certainly many of the elements that you suggest are there.

Ms CATE FAEHRMANN: Dr Bonning, thanks for coming today. We've got this strange situation where you're actually behind me on the screen, but I have to look forward. But we'll manage. You've got a couple of statistics in your submission that I found particularly interesting. It's about the elective surgery waits. You've got one. It's a comparison of two years—it's not a comparison of the same thing, but the data is from two years apart. The first one is from 2020-21. Your submission states that the poorer outcomes in terms of waiting for elective surgery means that from 2020-21, 3,158 people who were waiting for elective surgery in a public hospital in New South Wales either died or were unable to be contacted, which was up from 2,704 the year before. That's a difference of, just roughly, almost 500 patients. But in the previous paragraph you've actually got a more updated figure, which states:

> At the end of the April-to-June 2022 quarter, there were 18,748 patients on the waiting list ready for surgery who had waited longer than clinically recommended, compared to only 2,037 at the end of the January-to-March quarter in 2020 …

Sorry, that was a lot of statistics. But if you put those two together, doesn't that seem to imply that the next time we get that data for who died waiting for elective surgery, it's going to be extraordinary in terms of the increase of people who have died because they have waited longer than is clinically recommended?

MICHAEL BONNING: With much of that waiting beyond clinically relevant time frames, we recognise that for many people's elective surgery that will cause disability, pain and impact their ability to work. Until we see the data, while I can agree with you that those statistics may well see an increase in those people who might have died or had been unable to be contacted while waiting for their surgery, it's very hard to put a figure on who those patients are and what is going to happen to them. What we know is that anyone waiting—18,000 people are waiting for elective surgery longer than is clinically indicated.

We have clinical indicated time frames for a reason. That is because that is when we know that we should have a specific time frame that meets the needs of the patients to actually be clear about what their health outcomes should be. We know that when patients know those outcome time frames and then we aren't meeting those outcome time frames, that is actually quite detrimental to both their physical and also their mental health because they know that, if we leave them for longer than they should, that's distressing and quite unpredictable for their life and clinical outcomes. Again, as we have done in the submission, we have to wait for verifiable data. But, certainly, the implication is that waiting longer for health access leads to poorer outcomes, including death.

Ms CATE FAEHRMANN: Yes. I think you're being very diplomatic there, Dr Bonning. It is a huge increase, from 2,037 to 18,748 patients waiting for elective surgery. What is that? A six-fold increase or something, if not more, actually. So that can't be good. That's not a good indicator, is it?

MICHAEL BONNING: While it is a nine-fold increase there, we don't know whether that would result in a nine-fold increase in the number of people having died waiting. I'm going to keep my clinician-scientist hat on for a sec and sit on the side of I would want to wait for evidence. But I have to agree with the fact that waiting longer leads to poorer outcomes. We know, from across the board, that that is not just death. That is poorer outcomes for someone who then has their surgery and lives and is now disabled, is now in chronic pain, is now

unable to work. It has a significant detriment and drawdown on our ability to provide health care because many of those patients will now require more ongoing health care than they would've required otherwise.

Ms CATE FAEHRMANN: Thank you. That's clear. NSW Health is appearing this afternoon. Their submission talks about how they're trying to address all of this, of course. What measures are you seeing that they're putting in place—that are effective—to deal with this backlog of elective surgery, if any? And how many years? Do you see a light at the end of the tunnel?

Is there a plan to have dealt with a significant portion of this hopefully, for example, by two years, by three years, by four years? Does the AMA have a clear idea of that? Have you been discussing with NSW Health what that looks like?

MICHAEL BONNING: We have been, and I think I'll split my answer into two parts. The first is that the ability of our system to ramp up significantly with regards to elective surgery is hampered by workforce and the ability to attract and retain workforce into the State public health system. I will provide more information in addition to what has already been provided in our submission on notice if that is okay with you.

The CHAIR: Thank you, doctor.

MICHAEL BONNING: What we see with regards to the planning from NSW Health with regards to elective surgery, however, is while there is a commitment to a plan, we have seen that at most turns over many years this ability to reduce significantly its elective surgery time frames has been hampered or had hurdles that are completely recognisable and plannable for—such as the winter surge of respiratory illnesses that often limits our access to beds for post-operative patients—meaning that we cancel surgeries on the day. The access and pay environment for surgeons, anaesthetists and other health staff, especially in rural and regional areas, means that many are taking or making less of their workload in the public, or doing less of their workload in the public and more in the private. So there is a distinct difference in access between those two areas, especially in places where there is a thinner market such as smaller regional and rural areas.

Even beyond that, we know that with significant increases in funding, it also can't make the system run harder unless you put in place the ability to ensure that workforce is not just appropriately compensated but given that plan well in advance and it includes all of the parts of the pipeline, so all of the way from outpatient appointments where we see a significant hidden waiting list—so people who are waiting to get on the waiting list for their elective surgery—all the way through to their ability to then be seen multiple times in a clinic prior to their surgery, including pre-anaesthetic clinic for those people with chronic diseases that means that they need special care for their anaesthetic or post-anaesthetic care and then their discharge and rehab. There are a number of components to that. We will provide more information.

Ms CATE FAEHRMANN: Thank you. In your submission you mention the extraordinary length of time that NDIS patients are spending in hospitals waiting for assessments, waiting for specialist disability accommodation. The average participant waits 196 days for their request to be fully considered. What are your thoughts about ways in which they can be addressed? Just going to potentially a Federal issue at the moment, surely additional funding to ensure that we have enough specialist disability accommodation is much more needed now than tax cuts for the wealthy.

MICHAEL BONNING: As a healthcare provider, I'll always say that the most important thing is how we take care of those people in our community who are less able to take care of themselves. Having access to appropriate disability support services, accommodation, the care providers in the community and focusing very specifically on that pathway from needing to discharge out to the community, it would seem as an observer and someone who is not acutely involved in that part of the sector that that is an extraordinary amount of time and that most services, if they were being provided at the relevant level, should not take 196 days to be able to be provided.

What we'd say is that it's a complex team requirement and we need to train that workforce but we also need to deploy that workforce into the right environments. I note that most of our rehab services are hospital-based, and that providing for and developing community rehab services so that those with disabilities might live in the community but have easy access to rehabilitation services rather than staying in hospital where the rehabilitation services are would be a better use of community funding and resourcing and better for the individuals involved.

The Hon. AILEEN MacDONALD: In the AMA submission, you've got six recommendations. I just turn to the first two with regard to the Federal Government contribution. The New South Wales Government can advocate for that as well but I was just wondering what steps has AMA made towards advocating for an increase in that funding and the removal of the annual growth cap?

MICHAEL BONNING: This has been a clear and one of our most prominent campaigns over the last few years, mainly because we have seen that the 50-50 funding split between State and Federal has been very

effective in recognising that all of government, Commonwealth and State levels, is responsible for all of people wherever they happen to live and that those individuals should be supported by both those governments to an equal amount.

We have run a significant campaign called "Clear the hospital logjam", which is exactly about this issue. It's about access block, it's about access to elective surgery, and it has been front and centre with our dealings with both Minister Hunt and now Minister Butler with regards to this. It's also on a State level with Minister Hazzard that we've been very clear that that is one of the key underpinning facilitators of what will actually drive better outcomes. Because, if hospitals and States are penalised for wanting to deliver more care that is effective, timely and appropriate, then what we see is the outcome we see today, which is growing lists of people who are waiting for access to care or access to waiting lists, so even the hidden waiting lists of getting on at the start point because we don't have enough public outpatient clinics that see those patients who need our help.

What we know is that in the acute care sector there are many people who will wait far too long because our hospitals and health systems need to wait until next funding year to bring them in and actually take care of their issues, and that contributes to some of the backlog that we see alongside just overall demand increase. We want to fund performance improvement, not defund or disincentivise for when people go over what we would see as a normal funding cap.

The Hon. SCOTT FARLOW: Thank you for your submission, Dr Bonning. Going through it, I think you're saying that a lot of factors play into the issues that we're seeing when it comes to ambulance ramping and the pressures on a hospital. But the primary issue is the non-urgent presentations that are occurring in our hospitals, and that is effectively a symptom of the lack of GPs who are coming into the system and is particularly pronounced in rural and regional communities. Is that correct?

MICHAEL BONNING: Yes, that's one of the significant causes.

The Hon. SCOTT FARLOW: In the funding models that exist in that space, what are you seeing to attract GPs into those positions in the primary care market? Are there initiatives underway at the moment that are seeing an increase or potentially could see an increase, particularly in rural and regional communities?

MICHAEL BONNING: We think, especially in rural and regional communities, you get more value out of the practitioners that you have in your system there by engaging them into the public sector in their private rooms. Models such as what's been done in Murrumbidgee, which is about a single employer for trainees, have been seen favourably by those trainees who are going there. We also know that models that are run in other States, such as Queensland, have been effective in some of those environments—though what they do is pull the majority of the care provision into the hospital sector in rural and regional, rather than keeping some of it or the majority of it in the primary care sector. That's been both a solution, but it also has with it its inherent costs and concerns about how you staff effective primary care in the community alongside effective hospital-based care for more urgent needs in rural and regional environments.

I was in Armidale and Tamworth last week on this same issue and saw models and approaches being piloted which go all the way from teaching through university through to the training and then support for primary care—so using virtual hospital support for primary care, which we know is being proposed there. Similar things have been piloted in the Far West LHD in New South Wales, and those options are valuable to support primary care. Also, while it is not part of this Committee's purview, we need to see an increase in the Medicare rebate for access to primary care services, because there are many patients who avoid certain health care because they are unable to afford it. We know that those people will then end up in emergency departments with unplanned and deteriorating health that requires more significant healthcare interventions. They're some models that have worked in rural and regional areas.

What we also saw was a significant improvement from the Western Sydney Local Health District, their integrated care program, which has been a part of our submission and looked at rapid-access clinics for both GPs and the emergency department—to move patients, rather than into a hospital bed or rather than missing the opportunity to intervene early. Rather than wait weeks or months for an outpatient appointment, someone could be moved in there very quickly. It also recognises that in areas where the community is more culturally and linguistically diverse, we need more people to help individuals navigate care. We need people at the community level helping to inform better health behaviours, including the seeking of care, because many people who have less familiarity with our Australian healthcare system may well wait rather than seek care early. That can mean that they then have poorer health outcomes. So there are a number of models, some of which are in the submission. We will also take your question on notice, in addition, to provide some other models that are available and that the Committee can consider in their own time.

The Hon. SCOTT FARLOW: Dr Bonning, with respect to the New South Wales position compared to other States, in particular, the diagram that you've included in your submission at figure 1 shows the number of approved/available public hospital beds per 1,000 population aged 65 and over for all States and Territories. Maybe on notice, will you provide those figures on a State-by-State basis to see how New South Wales compares? Just generally, from the position of the primary care space and GPs, I am interested in your reflections on New South Wales' performance compared to other States. From your position, is the New South Wales system doing much of the heavy lifting, in a sense, to compensate for the gap that exists in primary care access?

MICHAEL BONNING: I think there are two important parts to that: There is a gap in primary care access that's been driven by the workforce. We need to include and engage more doctors in the primary care workforce, through training but also through the subsequent job that they end up taking on after their fellowship training. We see that many of the patients who go to emergency could have reasonably been managed in primary care and that access to care services throughout the day needs to be managed. I want to be very clear that the provision of urgent care services in the community—so rather than urgent care centres—is about strengthening primary care and ensuring that what we have in the community is the ability for those people who would otherwise end up in emergency to have access to a clinician who knows them or a practice that knows them and is then able to intervene at a time which is clinically relevant. The ability of the hospital to manage a patient with what would have been a UTI yesterday but is now a kidney infection today means that primary care should be at the forefront of those reforms.

Secondly there, as well, we have to link up that integrated pathway. There are patients who are too complex for primary care, not yet sick enough for the emergency department and too poor for a private specialist. They need access to public outpatients. Public outpatients is a significant benefit to the community. It also means that we have a better understanding of where the healthcare needs are in our community, because they are actually seen by our hospital system. In that regard, those patients will often then be handed back to primary care and managed successfully, without the need to end up in our emergency departments.

If I might make one last comment, primary care is struggling. You have recognised that through our submission and through the submissions of many others, and your own experience. If in New South Wales we add payroll tax concerns to what is already going on in the very tight financial circumstances for primary care, we add another disincentive for people to run practices, for people to work in primary care. We need to be forthright about the fact that general-practice primary care is an incredible public service that delivers high-efficiency, low-cost care, and that pulling money out of that by way of a payroll tax on primary care would be a massive disincentive but also potentially a massive disaster for primary care in New South Wales. That is on the horizon, and it's something that we as a professional body see as a major potential impact for a system that is already under a lot of stress.

The CHAIR: I know the Hon. Lou Amato has a question, but we're over time by about five minutes already. Would it be alright if you put your question on notice and asked the first question for the Government in the next round?

The Hon. LOU AMATO: That's fine, Chair. No problem at all. Thank you for that.

The CHAIR: On that note, thank you very much, Doctor. I have to say your responses have been very comprehensive to each and every one of the questions and provide us now with much additional information, which will sit very nicely with your submission on behalf of the organisation. So thank you very much and I thank the AMA (NSW) for all the great work it does. Thank you very much.

MICHAEL BONNING: Thank you very much, Chair. Thank you, members, for having the AMA today.

The CHAIR: We'll conclude that first witness and we'll move straight on to our next tranche of witnesses.

Dr TONY SARA, President, Australian Salaried Medical Officers' Federation, sworn and examined

Dr LIZ SWINBURN, Senior Emergency Physician, Royal North Shore Hospital, affirmed and examined

Mr JERRY YIK, Head of Policy and Advocacy, The Society of Hospital Pharmacists of Australia, affirmed and examined

Dr JONATHAN PENM, Chair, NSW Branch Committee, The Society of Hospital Pharmacists of Australia, affirmed and examined

The CHAIR: Welcome to all for the next part of the hearing this morning. Just to confirm for both respective organisations, starting with ASMOF, first, your submission has been received, processed and stands as submission No. 29 to the inquiry. It provides valuable background for the questioning that we'll have later after opening statements. Take the submission as read, so in the opening statement we'll come to in a moment, you don't need to quote slabs out of this. You can formulate some general observations. With respect to The Society of Hospital Pharmacists of Australia, equally, thank you very much for your submission. It has been received, processed and stands as submission No. 15 to the inquiry and has been uploaded onto the inquiry's webpage. We will start with the society. Will it be you, Doctor, or Mr Yik making the opening statement?

JONATHAN PENM: I'll make the opening statement. Good morning, Chair, Deputy Chair and members of the Portfolio Committee. SHPA is a membership organisation representing 6,000 hospital pharmacists and colleagues. With respect to ED overcrowding and ramping, hospital pharmacists can ease up capacity in emergency department in multiple ways: first, by taking a timely and accurate medication history as part of the admission process, to facilitate fast admission to inpatient wards; second, by identifying medication-related presentations and resolving these issues in the ED, preventing the need for the patient to be admitted; and, third, by supplying discharge medicines for discharges from the ED.

With respect to access block, our members are telling us that pharmacy is often the hold-up to discharge. This is because there are just not enough pharmacists employed in New South Wales hospitals. In New South Wales public hospitals, there are approximately 25 per cent more inpatient beds than Victorian public hospitals. However, there are 25 per cent less hospital pharmacists in New South Wales compared to our Victorian counterparts. Our members tell us that the average time to complete a patient's discharge prescriptions is between three to four hours. This delay is due to inadequate pharmacist staffing in addition to complex patients taking up to 20 medications with complex dosing, many medicine changes and rectifying prescription and prescribing errors before the dispensing process can even begin.

Furthermore, our members tell us that patients are often kept in the hospital unnecessarily over the weekend as inpatients, as there are no pharmacy services on the weekend to provide medications. Hence, the underinvestment of pharmacists in New South Wales' hospitals has contributed to access block. Our members in New South Wales know their pharmacy departments are the most poorly resourced in Australia and addressing the workforce gap is key to ensuring pharmacists can do their part to assist with health system capacity, ED overcrowding, bed flow and access block.

The CHAIR: Thank you very much. That's a very concise and to-the-point opening statement. I'm sure it will lead to some questions which will help elucidate that further. To ASMOF—would both like to make an opening statement, given that there are specific roles there between the two?

TONY SARA: Yes, Chair. As the president, I will give a broader overview and Dr Swinburn is an emergency physician, so she can give the perspective of our members in the emergency department.

The CHAIR: That would be good, and share the time between yourselves. Thank you very much.

TONY SARA: Thank you for the invitation to ASMOF to make a submission to this hearing. Our union represents about 5,000 medical staff and access block affects the community, it affects us and it affects our members. Overcrowded emergency departments cause our members significant stress because they cannot look after patients properly. Sometimes they are treating them in corridors. Many emergency departments across New South Wales are currently a safety hazard for patients and for staff. They do not function properly when they are overcrowded. It's just not possible. There's nowhere to put people. People get forgotten. Things go wrong. And the literature is quite clear on that.

The root cause, as the inquiry has heard many times, is no empty beds in the hospital. We basically need more beds with staffing, and we need to move patients out that don't need to be in hospital anymore. There has already been evidence to the inquiry as to the reasons for that: Federal-State relations, persons waiting for NDIS funding, persons waiting for nursing home beds. Over the last few months there have been hundreds of persons

in our New South Wales hospitals that shouldn't be there that could be out in the community, providing an empty bed to put someone into from the emergency department.

The issue of hospital occupation and realisation is an important one. Many years ago we use to aim for 85 per cent occupancy. Many hospitals these days run at 100 per cent or greater than 100 per cent occupancy. It becomes impossible to run an efficient system. It's impossible to put patients into beds if they aren't there—if the hospital is overfull. So beds are an important issue. It's not the only solution but, from our perspective—our members in hospitals and emergency departments—it's an important one. So we need doctors and nurses to staff those beds.

Staffing hospital wards is not good at the present time. It has been made worse by COVID. It has been well publicised that our doctors in training—that's the interns, residents and registrars who will treat you when you come to the emergency department—are overworked, underpaid and worried about making mistakes due to fatigue. The number of doctors who report making mistakes due to fatigue has gone up this year from the survey last year. Our doctors in ED and hospitals are burnt out and they're leaving the system.

We are all working under industrial awards that haven't been updated properly in over 35 years. I was an intern under the medical officers award in 1984. It's essentially the same. We have been unable to negotiate fairer, proper, safer working conditions due to the Government's wages cap. As a result, work health and safety is not properly addressed in our workplace. We can safely say that it is no longer an attractive option to work in New South Wales. Doctors are leaving the State, they work as locums and make significantly greater amounts of money and have work-life balance, or they become visiting medical officers. They are paid more and they get better work-life balance. We need to do better for our patients in New South Wales and we need to take care of our doctors who are working in our public hospitals. We will never solve access block unless we get the beds and the staff, and think about how we run that system. I will hand over to my colleague Dr Liz Swinburn, who is an emergency physician.

LIZ SWINBURN: Thanks very much for this opportunity. I'm an ASMOF councillor but I'm currently working full-time in Royal North Shore Hospital emergency. Prior to July I spent 12 months as the medical lead for the virtual hospital looking after the COVID patients in the home, and for the 12 months prior to that I was the medical lead for Hospital in the Home. So I've got a bit of a broad range there. I also do some work in a private urgent care clinic in Sydney, do some shifts in a regional centre and do some work in a remote hospital which doesn't have any access block, which is very nice.

The CHAIR: Before you go further—and sorry to cut in—but did you have a chance to either see evidence on Wednesday from—

LIZ SWINBURN: Yes, I saw some of it.

The CHAIR: Did you have a chance to read the *Hansard*? The *Hansard* has just been published. You may not have. That was the actual record.

LIZ SWINBURN: I did watch quite a few of the submissions on Wednesday.

The CHAIR: That's fine. Thank you.

LIZ SWINBURN: That's why I know there were questions about had they worked anywhere else and interstate.

The CHAIR: Thank you very much. That's good.

LIZ SWINBURN: When this inquiry was announced, ASMOF put together a working group of doctors from across New South Wales hospitals. The clear agenda was to develop some outcome-based solutions rather than talk all about the impact. We've heard a lot about the impact on staff and patients. So, yes, I have read and listened to a lot of submissions. While there are some very innovative ideas being discussed, a lot of them aren't going to make a difference to access block. For example, urgent care centres and virtual fracture clinics are great, and they would be great for the community and great for patients, but the problem with access block is patients being admitted. There was a question about the non-urgent category four and category five patients, they're not really a big problem for access block. Access block is due to patients who are admitted and there are no beds in the hospital. It's patients who come who need to be admitted, patients who can't go home because there's nowhere to look after them, and patients who are in hospital and their length of stay is too long.

I want to mention four of the solutions that we think will go a long way to helping address access block. One is having a registered nurse in every aged-care facility 24 hours a day, seven days a week. This was mentioned the other day as an issue. This will improve end-of-life planning. It will also improve access to end-of-life medications because AINs and ENs aren't able to do a lot of things and will automatically send patients to

emergency. Along these lines we need more hospital outreach facilities, meaning a rapid response team that goes out and assesses particularly elderly people either in their own home or in their aged-care facility. These have been shown to stop patients coming to hospital, and that's what we need to do.

Our patient clinics are a really great way of preventing admissions. If there are chest pain clinics, clinics for rapid access neurology or stroke patients, or respiratory clinics, in emergency we can send patients home knowing that they have an appointment in two days to follow up. The alternative is admitting the patient to hospital, and that could be three or four days. The other big factor is consistent discharge policies and protocols to reduce patients' length of stay in hospitals. The surgeons are really good at this. They get paid when they operate, so they want to get patients home. They allow nurses or their junior staff to discharge patients. We are finding more and more with VMOs—the staff in the hospitals rather than staff specialists—as physicians, they get paid when they see the patient. So there's a financial disincentive to getting patients home quicker. We're all very keen to see some concrete action on solutions that will address the root causes of access block.

The CHAIR: Thank you. That's very good as well. Those two opening statements augment the very valuable detail in the submission. We will now move to questioning. I will start and my colleagues will probably have follow-up questions. Returning to a theme that Dr Sara commented on about a shortage of inpatient beds, do we know, or can we know—there are two parts to this question—how many "beds" we are short in New South Wales, and are there particular locations with respect to those shortages? It is a very general question, and you may need to qualify your answer with specificity in regard to how you answer it. It is about the issue of bed shortages for inpatients.

TONY SARA: It is a difficult question. I actually got involved with bed number planning when I was a young doctor. For efficiency reasons and to reduce costs, governments around the world have been reducing the number of inpatient beds per thousand of population. But what's been happening over the last five, 10, 15 or 20 years with the aging of the population is that we need more beds for those more elderly patients. I'm actually one. I'm 70. I'm in one of that cohort, so a little self-interest there.

The CHAIR: I've got a bit of self-interest as well.

TONY SARA: Thank you. I'm not an expert in bed planning these days, but I think Michael Bonning talked about the numbers that are there. I would struggle to give a factual answer to that other than to say my sense is that driving down costs and driving down bed numbers—we've gone too far. The aging of the population, the increased use of technology and the increased desire to take care of people—I suspect that we don't have enough beds. I think that's been shown by the COVID epidemic. Even before COVID we were struggling with bed numbers. When you couple not quite enough bed numbers with increasing drive for cost cutting, and COVID, and the cost shifting between Federal and the States with regard to health care, it's very difficult. So I could not give a factual answer.

The CHAIR: That's helping us understand it. I am listening, or observing—

LIZ SWINBURN: Can I make a comment to that too?

The CHAIR: Please, Doctor, go ahead.

LIZ SWINBURN: Agreed, I don't think we know how many we need. Also, with things moving, with COVID, we thought we needed heaps more beds than we did, but that was managed really well. The ministry of health in the State, we actually managed the COVID epidemic extremely well. We pivoted very quickly when things happened. We had set up amazing teams of doctors and nurses, who were able to call patients every day. There would have been so many more come to hospital if that wasn't in place. If we do everything the same as we do now, we will need more beds. But hopefully this is an opportunity to look at other ways of doing things and having more virtual hospitals allowing access.

A lot of GPs do virtual health now. Even with pharmacy, do we need to have a hospital pharmacist—I don't know; you might not like me saying this—to do the discharge dispensing in the hospital, or should it be sent to a pharmacy and then the medication gets delivered to the patient's home? If, as you say, patients are staying in hospitals six hours, or days, waiting for their medication to be dispensed, instead of employing more pharmacists, get pharmacists to visit the patients at home and go through their medication at home and check that they're all on the right medication rather than just doing the same things again. I would like to think that this is an opportunity to try to address some of those things and do things differently.

The Hon. MARK BUTTIGIEG: On one of the points that I think Dr Sara made with regard to the stress and WHS issues in these environments—and we've heard some horrific stories, obviously—I am interested to know, is there a fatigue management policy that's employed in these environments?

TONY SARA: There is an award that's significantly out of date. We've had some increases in terms and conditions via policy directive. Many years ago the Federal AMA did rostering rules, fatigue management things. We, basically, ignore them. We don't have enough staff. There is no incentive to properly cost the services we provide. The culture has been not to pay overtime. The New South Wales health system is based on the unrostered, unpaid wages theft of the hospital system of young doctors. That's been well and truly established. So it needs cultural change. It needs a new award. We need to look at the fatigue management processes. We need more money. We need cultural change. As you're probably aware, ASMOF is suing the State of New South Wales in the Supreme Court about these exact issues.

The Hon. MARK BUTTIGIEG: So just to clarify, NSW Health does have a fatigue management policy that hospitals are meant to implement or is it—

TONY SARA: No.

The Hon. MARK BUTTIGIEG: No?

TONY SARA: No, I'm not aware of one.

The Hon. MARK BUTTIGIEG: So you have this situation where, right across industry, these things are standard processes—for example, 16 hours in 24, door to door, home to home, rest breaks, all the rest of it—and this is not a thing in New South Wales?

TONY SARA: It's not in the award. We've got a policy where you should not work longer than 14 hours and you need a 10-hour break between shifts. That came in last year. But until that point in time there was nothing. So if you're a surgical JMO or RMO and you need to come at six o'clock in the morning to do rounds with the patients before the boss comes and theatre goes late, it's seven, eight or nine o'clock, well, you go home at eight o'clock and you come back again at six o'clock in the morning, and you will do that for a term.

The Hon. MARK BUTTIGIEG: Right.

TONY SARA: You'll do that for 10 weeks times five days. When I was an intern, I did neurosurgery at Prince Alfred—a seven o'clock ward round in the morning, a 7.00 p.m. ward round at night and then you went and did your ward work after that. That term was still in existence two years ago.

The Hon. MARK BUTTIGIEG: You've got people dealing with people's lives who are working excessive, unbelievable hours and then having to travel home, presumably totally exhausted?

TONY SARA: Yes. The horror stories have been coming up for a long time of people falling asleep driving home. As a union, and as a union of doctors, we're seriously and significantly concerned. We've been banging the drum about this for years and years and years. It doesn't help patients; tired staff, fatigued staff, make mistakes. The literature is very clear on that. Other States and Territories have updated their awards. Their State governments have provided more money to the salaries and wages budgets. We have been unable to look at the awards in New South Wales for 35 years. As I said, we had one card left in our hand, and that was to sue the State Government.

The Hon. MARK BUTTIGIEG: Legal action, yes.

TONY SARA: I'm 70. I want to cease being the president with the legacy of a significantly safer, better award for young doctors, to take care of them so they can take care of the people they want to serve—the people of New South Wales.

Ms CATE FAEHRMANN: I will go to The Society of Hospital Pharmacists of Australia representatives first. It's quite extraordinary, really—in your submission you state that there are two-thirds of emergency departments in New South Wales that don't have a hospital pharmacist over the weekend. We have heard already during this inquiry just how bad 8.00 a.m. on a Monday morning is for everybody not being able to be discharged or seen. What is the response from NSW Health or the Minister? I assume you do advocacy and request that policy changes in some ways. Why is there such resistance? What are you getting back from the Government when you are telling them that our hospitals need more hospital pharmacists?

JERRY YIK: What we've been hearing from our directors of pharmacy and hospital pharmacist movements in New South Wales who do make requests to their chief executives for more resources, our understanding is that the chief executives at the hospital—that's of the hospital or the LHD—are allocated funding for additional staff. Unfortunately, unlike our medical colleagues, pharmacy in New South Wales, which is unlike other States, falls under the purview of the Chief Allied Health Officer. So when you do have additional funding for pharmacists in New South Wales public hospitals, usually you're carving up that money with speech therapists, occupational therapists and other health professionals.

So pharmacy, by that nature, gets a much smaller slice of the pie compared to other States where pharmacy sits by itself outside of allied health and alongside medical. So I think having that recognition of pharmacy services and the importance of pharmacists under how NSW Health is structured is really, really important because the way that it's currently structured means we're just not getting enough pharmacists. And absolutely no disrespect to my allied health colleagues, but when things go wrong with medicines you can absolutely cause a patient death. We have seen that before in New South Wales. Contrast that to areas in allied health disciplines, you can have really bad things happen to patients as well but unlikely to result in patient death.

In saying that, we've heard over COVID in the last few years where there has been additional funding for clinicians due to COVID, only some of that has trickled down to pharmacy departments. We know directors of pharmacy have been making bids and requests to their chief executives for more pharmacists. I know in one hospital they needed and asked for four extra pharmacists for two vaccination clinics and for the ramping-up of the intensive care units; they were given one. And that's a lucky case, to even have one additional pharmacist. I think that's actually contributing to a lot of the stress and burnout and fatigue that we've seen. That already existed well before COVID, it's just even worse now with COVID.

Ms CATE FAEHRMANN: As a pharmacist's daughter, this is very dear to my heart. You have also mentioned a model of care implemented at The Sutherland Hospital. Would you mind telling the Committee how that model of care has impacted positively on emergency departments? This is above recommendation 3—I can't see the page number, I'm sorry.

JERRY YIK: Yes. Essentially, at The Sutherland Hospital they've invested in an emergency medicine pharmacist. I think my colleague Dr Penm has talked about the benefits that emergency medicine pharmacists bring. We know from statistics that each year there are 400,000 medication-related presentations to ED, and then, additionally, 250,000 medication-related hospital admissions onto inpatient wards. So patients come to hospital, come to an ED, and a lot of these medication problems could be there are shortages of medicines. Dr Penm told me today that according to the Therapeutic Goods Administration there were 300 medication shortages. We see this all the time, actually—patients that have run out of their insulin. What do you do when you run out of insulin and there is a shortage and the pharmacy is not open? Well, you go to the ED. We know patients go to the ED when they run out of their methadone, when they run out of their pain medicines.

So when there are medication supply issues, absolutely, patients end up in an ED. That's where a pharmacist can resolve those medication supply issues. If they're there purely because of a medication-related issue—be it supply, be it they're experiencing a side effect, a potential drug interaction—the pharmacist there can understand what the problem is and resolve it from the ED. That would actually then save an admission to the ward completely. So in the setting, say on the weekend, where you don't have a pharmacist, the doctor, who is obviously really busy dealing with a lot of admissions, and the nurse, who may not be able to detect a drug interaction or detect an adverse event, they not be able to understand what the actual problem is and attribute it to a medicine, and then they have to admit that patient to the ward. If you've got a pharmacist there, they can actually find out what the issue is and then resolve it from the ED, and get them out of the ED in under four hours.

Ms CATE FAEHRMANN: Dr Sara, I just wanted to go to you. You said at the beginning of your statement, "We will never solve access block unless we get the beds and staff". You also said, "It's no longer an attractive option to work in New South Wales." That's definitely not what the New South Wales Government tells us every time we ask them about this issue. Where are doctors paid more? Where are medical officers paid more? Where are they getting a better work-life balance—because you suggested that is what they're going off to do, I assume, in other States?

TONY SARA: Yes. The award terms and conditions in both Queensland and Victoria mean that a staff specialist there gets approximately $50,000 more to work there.

Ms CATE FAEHRMANN: I wouldn't say that very loudly in New South Wales at the moment.

TONY SARA: So that's $50,000 more to go. Young doctors hear this anecdotally and instead of going to the bush or instead of setting up practice in New South Wales somewhere, they'll say, "Look, better staffing, better terms and conditions" and "I like the sun" or "I like the cold of Melbourne"—whatever it is—and they go interstate.

Ms CATE FAEHRMANN: The State governments must be offering more incentives because there is a part of all this, of course, that is—this is working in public hospitals?

TONY SARA: This is the awards, yes. Again, our award hasn't changed; the staff specialist award hasn't changed for 15 or 20 years, apart from the 2½ per cent. I could go and work in Queensland tomorrow and get an extra $50,000 in my hand to go there. It's the same in Victoria. It's the same for young doctors. That's the way it is. I have brought that to the Minister's attention and he said, "Yes, I understand that young doctors can make

more money in other States and they choose to come here for their training." The reality is that if you are looking for a training scheme, you will go wherever you can get a training position because we don't have enough training positions. But, at the end of the process, you are going to make decisions based on interest, your family and what you can earn.

The health budgets in Queensland and in Victoria have more money for terms and conditions and the awards are better. There is true bargaining. There has been true bargaining in Queensland for a very long period of time. Campbell Newman tried to stop that, you may recall, in 2014. Subsequently, he was removed from government and they went back to proper bargaining. The doctors and the government say, "What do we need?" There is to and fro and there are negotiations. But, again, it is $50,000 more to work in Queensland as a staff specialist than in New South Wales, similarly for young doctors. Young doctors are not nearly as under the pump as in our State. There is no interest in the health system. Our system is based on wages theft for young doctors.

It is much less so in Queensland and much less so in Victoria. It was well-publicised that the Victorian Labor government provided hundreds of millions of dollars to budgets for hospitals for young doctors to make their lives better and to make it safer. It's just the way it is. Do I sound disappointed? Do I sound burnt out about it? Yes, because we are. That is why, as I said, we have played the last card in our hand, which is to sue the State Government. We are having mediation in two weeks' time to attempt to resolve it and our answer is a new award. It'll take money and it'll take time and cultural change. We can no longer continue to do this to our young doctors because it flows on to patient care. Patients are harmed as a result. I'm emotional about it, I apologise.

The CHAIR: No, there's no need to apologise. Doctor, this is an obvious point to make but just for the record, that's $50,000 per annum?

TONY SARA: Per annum, yes.

The CHAIR: That's fine. I just wanted to ask.

The Hon. MARK BUTTIGIEG: Net of tax.

TONY SARA: That's gross. After tax it will be $20,000 to $25,000, depending.

The CHAIR: I just ask so that it is on the record clearly. Thank you for that.

The Hon. LOU AMATO: Thank you all for attending today's inquiry. My question is more for Mr Yik and Doctor Penm. In your submission, recommendation 1 states:

> NSW should become a signatory of the Pharmaceutical Reform Agreements (PRA) in order to provide sufficient medicines supply on discharge reducing reliance on primary care at Transitions of Care and prevent unnecessary Emergency Department presentations.

I was reading that and I thought that sounded pretty good. You then say:

> Patients being discharged from public hospitals in NSW are currently supplied 3-7 days' worth of discharge medicines …

Can we go a step further and maybe get your opinion on it? In other jurisdictions, particularly overseas, pharmacists are allowed to do a lot more than just dispense medication. I know even our pharmacists are doing a bit more. Let's say if we can broaden that scope for pharmacists, would that relieve the pressure on—I can see the witnesses smiling. Overseas pharmacists do a lot more. Would that relieve some of the pressure, particularly in rural and regional areas, if pharmacists were allowed to do more?

JONATHAN PENM: I will answer that one. You are absolutely right. Pharmacists have an extensive range of medication expertise. They study for four years at university with a one-year internship with a very rigorous board exam at the end. It is five years of training just medicines. It shows time and time again that when we compare pharmacists prescribing or charting, in our case, with our medical colleagues, because of our focus on the medicines and our focus on medication safety, we often will pick up 70 per cent to 80 per cent mistakes within the patients that we see in comparison to those that our physician colleagues have looked at. I think they do a great job, but it just shows the difference in focus. Our patients right now are much older and more complex than they have ever been before. Our patients on average are on 10 medicines a day. We were just looking on the TGA and there are over 20,000 medicines registered in Australia. There's no way people can stay on top of this, unless they are giving it their time and priority. As pharmacists, things that we do just to be able to help with that paperwork are accurate medication histories.

A lot of the system assumes things are happening that aren't happening. They assume we know what medicines people are on normally; we don't. When we are taking history, it's often incomplete, inaccurate and causes even more harms in their admissions. Pharmacists do a good job taking those histories and a good job charting those medications so that our medical colleagues can actually focus on the diagnosis and treatment, which is what they are trained for and what they are good at. We want them to focus on that and we can take away their other issues as well as assisting with the discharge. We are finding again and again that patients are starting new

medicines and they are not told much about them. Pharmacists, having that expert medication knowledge, are happy to talk to them and help them have the self-management techniques that they can use to look after themselves. But we just don't have time to talk to them and we don't have time to tell them. Patients are leaving the hospital with new and complex medicines and they don't know what they are taking. That's a big problem.

JERRY YIK: Just going back to your question around what pharmacists can do more in their scope of practice as well, this absolutely has been occurring in other jurisdictions. I know in Victoria and in Western Australia it is quite advanced with what we call partnered pharmacist medication charting. At the moment in hospitals where you have junior doctors having to chart patients' medicines on admission, there are a lot of errors involved because they are really busy and they are still perhaps new to the hospital. A lot of the pharmacists do pick up a lot of prescribing errors when it comes to inpatient charts. In other States, we've got this model of care where pharmacists are actually doing the charting of the medicine and the doctor just signs it at the end. This has been demonstrated by economic evaluations to save, I think, over $700 per admission and greatly reduce the medication errors as well.

In Australia I know the topic of pharmacists prescribing is quite a hot topic at the moment. I would say that partnered pharmacist medication charting in hospitals is the first iteration of pharmacists prescribing in the Australian landscape. If we have more pharmacists in New South Wales public hospitals and we expand their scope in the public hospitals and private hospitals to chart medicines, absolutely we would be seeing faster admissions in EDs and onto the wards, we would see less prescribing errors, less medication errors and, most importantly, we would be freeing up doctors and nurses to spend more time with patients at the bedside. That has actually been one of the major reasons why other States have pursued this, because junior doctors are spending their time getting medication charts charted and then getting a page from the pharmacist saying, "Hey, there's an error. Can you please fix this?" In other States they have better utilised the expertise of hospital pharmacists to do that charting, and junior doctors and all doctors in the ED have more time to spend with the patients instead.

LIZ SWINBURN: Can I speak to that? At North Shore we have a trial where a hospital pharmacist is doing the prescribing, and it's fantastic.

The CHAIR: It's good to have that knowledge.

LIZ SWINBURN: Some of these patients have 10 or 15 medications that they are on. For the pharmacist to go through and reconcile—they ring the pharmacist and the GP and work out exactly what they are taking because they will just come in with a big plastic bag full of all these medications. It is very cost-effective and time effective.

The CHAIR: That's very helpful to know.

The Hon. LOU AMATO: Do you think there is scope for pharmacists to do more than just dispensing medication? As I said, I know that pharmacists in a lot of countries overseas do a lot more than just dispense medication. I am just looking at the amount of study that pharmacists have to do, but is there scope for them to do more than just dispense medication, particularly in rural and regional areas and outback communities to relieve that pressure on the health system?

JERRY YIK: Yes, absolutely. I know we've talked about inpatient charting already, but what pharmacists are expert at is actually undertaking medication review and preventing admissions in all areas, not just regional areas. We have heard from AMA already today, who have talked about outpatient clinics and outreach services and services into aged-care facilities. Given that we know there's 650,000 admissions or presentations to ED that are medication related, if you have pharmacists that are providing these outreach services or outpatient services, we can absolutely prevent so many of these. We know that approximately half of these are preventable according to data and research.

Just for example, in outpatient clinics, if you had pharmacist-led outpatient clinics for stroke patients, for diabetes patients, for transplant patients, for cardiac patients—all these patients in these cohorts take over five medicines easily. They have really complex medicines that require dose titration, modification of doses, looking at their lab data to adjust the doses as well, and when any of that goes wrong, those patients end up in ED. They're INR's too high so they're bleeding out. All these issues are medication-related and we know these patients end up in ED. If you have pharmacists—that could be hospital-led outreach services or teams, or they could be federally funded via home medicines reviews or residential medication management reviews—who can go and see the patient while they're at home or at the aged-care facility and detect those errors before they become serious errors, you are able to prevent those admissions to ED and admissions to the ward as well.

JONATHAN PENM: I just want to add to that, Lou. The reason I talk about training is that we are already trained to do this and we already do do it. The reason we can't do it is we don't have enough staffing. We've been told, "Stop talking to them, just get them out of the hospital. Stop making sure that they're okay. Just

get them out; get the medicines." So we're being forced to focus on dispensing, not because that's what our primary role is. We do a lot of the clinical services, we make sure that we resolve medication safety issues. A lot of the programs in the hospitals are led by pharmacists. Antimicrobial stewardship is led, often, by a pharmacist and a doctor. Now we've got opioid stewardship standards. We know high-risk medicines are causing harm and pharmacists can prevent them. We don't have enough pharmacists, and then we're being told, "Just get the medicines. Just get them out." That's really stopping us.

TONY SARA: ASMOF is not opposed to increased skilling and scope of practice of the experienced pharmacists in our hospitals. But where Mr Amato seems to be trying to take us is the Queensland trial of pharmacists prescribing and dispensing, which has been universally condemned by the medical profession. The newspaper tells us that the Pharmacy Guild, which is essentially a small business owners' association, has approached the New South Wales Minister for Health to have a trial similar to the Queensland one. There was an article in *The Medical Republic* in the last week by Holly Payne that demonstrated that all these claims of pharmacists prescribing elsewhere in the world—New Zealand, Canada, the UK—are not nearly what the guild is telling us.

There's a lot of turf war going on here in the Queensland pharmacy prescribing trial, and I don't know that New South Wales should go down that road. ASMOF certainly does not support independent prescribing in community pharmacies. We strongly support our hospital colleagues. They're very competent, they're very experienced, they're very skilled, and an increased scope of practice for them in our hospitals, and more of them, would be welcomed. But I don't believe that this inquiry should go down the road of arguing for community pharmacies independently prescribing. I don't perceive it has got a lot to do with ramping in our emergency departments, Chair. Thank you.

The Hon. LOU AMATO: I wasn't aware of the Queensland system or trial up there at all. I've been talking from my family's own experience, having come from overseas, my mother being a nurse overseas and how the system was over there. I was looking at ways that we can alleviate the pressures on the system while delivering quality care to patients. That's what I'm just looking at.

The CHAIR: Dr Swinburn, did you have any additional comments?

LIZ SWINBURN: Yes. One thing that keeps on coming up is that access to GPs is a big issue with access ramping, and I don't think that's actually the case. GPs are wonderful. They are sending a lot of patients to emergency, and they're the ones that need admission. They are sort of the gatekeepers in a lot of ways. The access to GPs in the country, particularly—if they go to the emergency department instead of going to the GP, and they are sort of GP-type patients, they're not contributing to access block. They're going to be seen and they're going to go home.

I think you've just got to be careful when you're looking at—what you're talking about is that access to GPs and GP patients going to ED is not an issue with ramping and access block. Even if the ambulance takes them there, we will off-load patients into the waiting room, if they don't need a bed, so that the ambulance can keep on going. I think you've got to be careful what this inquiry is for and what solutions you're looking for because having more GPs is not an issue.

Something like the urgent care centre where I work, it provides access to imaging after hours. If you're a GP and you see a lady, say, having a miscarriage at 4 o'clock on a Friday afternoon, and they need an ultrasound, you can't get an ultrasound unless you send them to hospital. And even in the hospitals, they're on call back—they're not on site Saturdays and Sundays. When they're talking about urgent care centres, if there's urgent care centres that actually provide that imaging—CAT scans, ultrasounds, X-rays, pathology—that's going to make a difference to patients going to hospital or seeking care. But, again, it's not particularly an access block problem. They are two different issues.

The CHAIR: Point taken. Thank you. That has brought us to the end. I'm sure we could go on, but we do need to move on to our next round of witnesses shortly. On behalf of the Committee, thank you very much. There has been very rich evidence that helps inform this inquiry, to be read in conjunction with, obviously, the most helpful submissions you've made, respectively. Thank you very much and thank you for the great work you do in the public hospitals.

(The witnesses withdrew.)

(Short adjournment)

Dr KENDALL BEIN, Emergency Physician, affirmed and examined

Associate Professor JAMES MALLOWS, Senior Emergency Physician, Emergency Staff Specialist and Director of Emergency Medicine Training, Nepean Hospital, affirmed and examined

The CHAIR: We will move to our next two witnesses. Thank you both, gentlemen, for coming along to provide evidence to this important inquiry. We appreciate it. It may well be your first appearance at a parliamentary inquiry. This is not a combative exercise—no ambushing and trapping. We're just grateful that you've made the time. We've had some other very powerful evidence that was provided by clinicians on Wednesday, which you may be aware of. We're looking forward to hearing from both of you. Thank you very much. We know you're very busy in your own right. I invite you both to make an opening statement.

With respect to your submissions—and we are most grateful for them; they're very comprehensive in detail—Associate Professor, yours has been received, processed and stands as submission No. 26 to the inquiry. It has been uploaded to the inquiry's webpage and obviously forms evidence to our inquiry. Dr Bein, yours is submission No. 20. It has been gratefully received. Once again, it is very comprehensive, and we thank you for that. It has been processed and uploaded to the inquiry's webpage and also stands, obviously, as evidence to the inquiry. It is very valuable and important evidence. You can take both the submissions as read, so there's no need to quote large chunks because we have read them and we have them in front of us. Nevertheless, you can obviously draw on elements that you want to draw to our attention. That, no doubt, along with other matters you raise in your opening statement will be the cause of questioning. We have members from the Opposition, the crossbench and the Government, all from the Legislative Council, and we will share the questions between ourselves after you have made the opening statements. Are you okay if we proceed on that basis?

JAMES MALLOWS: Yes.

The CHAIR: We will start with you, Associate Professor. I invite you to make your opening statement.

JAMES MALLOWS: My apologies in advance if it's a bit long; I haven't really practised it that much. First of all, I think this has turned into the access block inquiry. Reading through all of the submissions yesterday, a number of them clearly state that access block and ED overcrowding seem to be the main contributor towards ambulance ramping and the resultant problems this causes. To quote my own submission, ambulance ramping is the symptom, and access block and ED overcrowding is the disease. Second of all, I think I have tabled some additional evidence to the inquiry. This is data from August of this year regarding emergency department performance at Nepean Hospital. The first page is a graph comparing the number of admitted patients that are brought into the ED at 8.00 a.m., compared to ambulance TOC for the day, and you can clearly see that as the number of admitted patients at 8.00 a.m. increases, ambulance performance and TOC decreases.

The CHAIR: Sorry. We appreciate we're going to have much information presented.

JAMES MALLOWS: Yes.

The CHAIR: If you slow down just a little bit. TOC, can you please explain that to us?

JAMES MALLOWS: That's transfer of care.

The CHAIR: Where was this data from, again? Which establishment?

JAMES MALLOWS: This is from Nepean Hospital.

The CHAIR: Nepean. Thank you. Please proceed.

JAMES MALLOWS: No worries. No, I'm happy to be interrupted.

The CHAIR: I will try not to, if I can avoid it.

JAMES MALLOWS: The second page contains a table of the mean ED KPIs for August. The significant one I've highlighted is the number of patients per day on average with length of stays, LOS, greater than 24 hours—there are four of those on average per day. The "left at own risk", which is a combination of patients who did not wait for any treatments and patients who left before their treatment was completed—that's almost 10 per cent. Cancelled admissions are about five per day. That's where a patient is admitted, stays in the ED but is not transferred to the ward before they are discharged; they are discharged straight from the ED. Ambulance transfer of care was just over 50 per cent for the month of August, rather than the KPI of 90. Again, the number of admissions at 8.00 a.m. waiting for a ward bed was 20.

The third page—this becomes a little bit self-serving—is a map of the Sydney hospitals in the Sydney metropolitan area. Each time figures are released for emergency department performance, the hospitals at the

bottom of the list are invariably Westmead, Blacktown, Campbelltown, Liverpool and Nepean hospitals. When you look at this map, I've actually drawn a line—north-south—through Westmead Hospital, which equates roughly to the geographical and population centre of Sydney. You can see from the map there are twice as many hospitals on the east of this line than there are to the west. Emergency department performance for a hospital is seen not only as a function of the resources given to the hospital but related to resources surrounding that hospital—for example, other nearby hospitals, good access to GP services, access to specialist services and access to residential aged care facilities. Lastly, I would like to confirm that on Monday 26 September there were nine patients that morning that had been in the ED greater than 24 hours waiting for a ward bed, of which two had waited more than two days.

The Hon. EMMA HURST: What date was that?

JAMES MALLOWS: That was 26 September. On Tuesday 4 October, immediately after the Monday public holiday, there were eight patients that had been in the ED more than 24 hours waiting for a ward bed, of which one had stayed longer than two days. As an investigator for the Sydney-wide EVIDENCE trial, which looks at out-of-hospital cardiac arrests, I am also aware of a patient that, after suffering a cardiac arrest and being revived by ambulance crews at the scene, stayed in the emergency department for two days waiting for a ward bed. That concludes my statement.

The CHAIR: Thank you very much. It's a very clear, precise and most powerful opening statement. Before I pass over to Dr Bein, could I just please go to page 2 of your document about the KPIs?

JAMES MALLOWS: Yes.

The CHAIR: Let's take the first one, the presentations.

Ms CATE FAEHRMANN: Could we hear from the other witness—their opening statement as well?

The CHAIR: That probably may be the better way to proceed.

Ms CATE FAEHRMANN: Sorry, Chair.

The CHAIR: It was just a point of clarification. Sorry, I wasn't trying to be disrespectful. Dr Bein, why don't you please proceed with your opening statement?

KENDALL BEIN: Thank you for the opportunity to speak today. I am Dr Kendall Bein. I'm an emergency physician, working as a staff specialist at one of Sydney's inner city tertiary referral hospitals and trauma centres. I have an interest in hospital flow. I have authored or co-authored a number of journal papers on flow, and I was part of the Australasian College for Emergency Medicine's working group on access measures. But today I don't speak on behalf of any of the organisations that I'm part of. I speak only in a personal capacity.

If I can focus your attention on one thing regarding the issues of ambulance ramping and access block, it would be that this is an issue of whole-of-hospital flow. Ambulance ramping is caused by no empty beds in the ED. There are no empty beds in the ED because there are no empty beds on the wards to move the admitted patients to. You can't fix ambulance ramping or access block without solving the problem of whole hospital occupancy that, in New South Wales, currently stands at around 100 per cent. I'd like to table a document and, like Prof Mallows, present some data showing some details of patients access-blocked in the ED where I work. This is from September of 2022. I'd also like to note that every hospital has lists like what I've presented and what Prof Mallows presented. This is not unique to our hospitals. It's every single hospital. This is a system-wide thing.

The first two pages are all the patients who spent over 24 hours in the ED waiting for a ward bed, including some basic details and the length of stay. The second, as was mentioned by Prof Mallows in his submission, is the number of admitted patients waiting in the ED at 8.00 a.m. each day, and that's based on a daily report that we fill out for the ED. The reason that these patients remain access-blocked in the ED is because there are no empty beds on the wards. Unless the solution this inquiry finds provides more empty beds on the wards, then it won't fix the problem. Proposals like patient diversion, use of corridor beds or urgent care centres that don't produce more empty beds on the wards are not going to help. In my submission, I detailed some approaches that were focused on forward flow and how approaches that are not focused on forward flow, like corridor beds, don't solve access block or ambulance ramping. I offer an alternate approach and solutions based on human factors and on whole hospital occupancy. I'd be delighted to talk about them further.

The CHAIR: Thank you very much, Dr Bein. Just before I open up to questioning, can I jump back to the point that I was seeking clarification on earlier, Professor? On the second page of your helpful document, you've got a table. For argument's sake, let's take the fourth figure—ETP. What does ETP stand for, by the way?

JAMES MALLOWS: Emergency treatment performance, I think. That's a good old four-hour rule for that particular stat, whether you actually discharge a patient within four hours.

The CHAIR: So short-stay admissions—

KENDALL BEIN: Whether the patient leaves the ED within four hours.

The CHAIR: That figure is 40.9 per cent. That is an average figure, is it? I'm trying to understand.

JAMES MALLOWS: For the month, yes.

The CHAIR: So it's the mean figure.

JAMES MALLOWS: It's the mean figure of the daily performance.

The CHAIR: Okay. If everything was going swimmingly, so to speak, in a hypothetical example in that particular item, what would one hope that would be or expect that would be?

JAMES MALLOWS: So we're talking about ETP for short-stay admissions?

The CHAIR: Yes.

JAMES MALLOWS: Short stay is run by the ED, and that's where we put up patients that require six to 12 hours of work-up and treatments, perhaps even overnight, but the KPIs should have a total treatment time of 24 hours in the short stay. I think the KPI we have locally at our hospital is about 70 per cent.

The CHAIR: Thank you for that. I will first ask you, Associate Professor, and then the doctor. This is general in its scope, and I think I know part of the answer. With respect to the day before, we had some quite senior individuals from the New South Wales health system, involved in emergency care and related care, give evidence of their own personal experiences in their capacity as individual clinicians. Did you hear any of the reportage about that? Did you even see any of the evidence?

JAMES MALLOWS: I was actually working on the floor. So I don't have any—

The CHAIR: That's okay. That's just helped to inform me. Dr Bein, were you aware of any of that evidence?

KENDALL BEIN: I read some news articles.

The CHAIR: That's fine. I was just wondering because, if you actually had had the opportunity to see it firsthand and hear it, I was going to raise some particular points. But that's fine; I'll move on. With respect to the matter of beds inside the hospital to receive patients who pass through emergency departments, a key question coming through this inquiry, unsurprisingly, is are there enough beds?—as a generic question and the clarity around the way in which you might define the question of sufficient numbers of beds. So there'll be an ability to mitigate that step from the emergency department into the hospital ward per se. I'll ask both of you, starting with Professor Mallows, do you have a view about whether there are "enough beds"? Then, following on from that, how can we be specific about that, if we can be specific about that?

JAMES MALLOWS: There are a couple of points I wanted to make with respect to that, based on the journeys we've had at Nepean Hospital. The first thing I'll say is we opened a new tower in about 2013/2014. That gave us, functionally, a few more beds. I don't know how many. But it was definitely a significant uptick in the ED-available beds. For about the next 18 months afterwards, ED performance was actually quite good—2012-13, not good; 2013-14, very good because of the new tower opening up and new beds. So there was a clear association. Now—

The CHAIR: Sorry to interrupt, but is there consensus on that point—that improvement? Is there a consensus that there's a cause and effect there, that in fact the opening of the additional beds was directly facilitative of the improvement?

JAMES MALLOWS: Yes. That was a conclusion of the senior clinicians of the hospital, to the point that, when we opened our new tower earlier this year, there was the same clinicians saying ED performance is going to get better. Unfortunately, we were disappointed with the actual number of uptick in beds that we got. I made that point in my submission. The other thing I will make is—people do talk about inefficiencies on the ward. I think I make the point in my submission that hospitals are about as efficient as they can be. Certainly, at Nepean we run a very lean ship. But, certainly, in 2018, when ETP was first introduced as a hard KPI, there were some efficiency improvements we made at the hospital to improve flow, and did get some benefits out of that. There will be a combination of are there enough beds and are we using the beds properly, but I think at the moment at Nepean Hospital we are functioning about as lean as we can. We still have 20 admitted patients in the ED, waiting for a ward bed, at 8.00 a.m., which suggests that the hospital is 20 beds short.

The CHAIR: Can I invite you, Doctor—this issue of the linkage. You've got the ramping occurring because of the issues in ED and then the ED not being able to move people in a timely fashion onto the wards, into the hospital.

KENDALL BEIN: I would start by saying, yes, that's absolutely—ambulance are ramping because there's no empty beds in the ED. There are no empty beds in the ED because there are no empty beds on the wards. I do want to stress the idea that it's empty beds that we need. We probably need more beds, but mostly we need to make a system that makes sure that there are empty beds on the ward. If you've got a 500-bed hospital and you increase it to a 600-bed hospital but the system is such that the hospital will always run at 100 per cent capacity, you've now got 600 full beds and still zero empty beds, you've still got access block, you've still got ambulance ramping. It actually needs more of a system change to facilitate access block being fixed.

The number that tends to be pointed at is we need to be running at closer to 85 per cent occupancy rather than 100 per cent occupancy. In my submission, I provided at least one hospital's evidence that that's around about the right number. How many more beds, I think, was one of the other questions you asked—is there a way to calculate it? That's hard. Again, in my submission I give a bit of maths to say, "This is how you would start to go about calculating it." But this is a complex system with a lot of knock-on effects. There's always the "if you build it, they will come" principle, where an empty bed will become a full bed unless the system actually promotes forward flow, not just from ambulance to ED to ward but also out of the ward—discharge.

At the moment, we've got a system that promotes 100 per cent occupancy. I suspect, if you did the clever maths, you would find that we are grossly short of beds in all the hospitals. However, I think that, if you were to just provide those beds, magic them up somehow, you would still have a system that is aimed at 100 per cent capacity, and all those beds are now full beds, and we now have back to the same problem. So I think we need to look much more at doing the maths, figuring out what is required to make the system run within the expectations of the people, the doctors, the nurses, the system as a whole, but also we need to be looking at what is going to change the equilibrium state of the system to have 85 per cent occupancy as a general thing and the idea that an empty bed is not a bad thing; that's the shuffle space we need to actually manage the block.

I think that's going to require a lot more looking at human factors, which again I mention in my submission and am delighted to talk endlessly about, and also, as Prof Mallows talked about in his submission, the balance between elective admissions, particularly elective surgical work, and the acute care admissions. It may be much more of a balancing act. It may be that, if the State wishes to maintain its very good performance on elective surgical, that needs to be factored into these equations. But I really think we need to focus on the system and the equilibrium state of the system and look at it in terms of flow—the inputs, the outputs, the throughputs, where the snaggles lie that stop the flow—rather than just focus on, "If only there were more beds, everything would be fixed. If only we paid our doctors more, there would be fixed. If only we had more pharmacists, everything would be fixed. If only we had more GPs, everything would be fixed." It's a system problem.

The Hon. MARK BUTTIGIEG: I might just follow up on and tease that out a little bit because this 85 per cent to 90 per cent occupancy rate seems to be one the key—let's not refer to it as a silver bullet, but it seems to be a key thing that would go a long way to helping this problem. But in the submission, you say:

> Without a doubt the most troubling and tragic impact of ambulance ramping and access block is that it causes patient deaths.

So what we're essentially saying here is that, if you've got an acute input into the system via ambulances with people in life-threatening situations, then you need to prioritise and cater for that by creating that 15 per cent vacancy rate so that you can cater for that inflow and prioritise those people. How would that work in practice? Presumably, you're going to have this ebb-and-flow system where it goes from 85 to 100 and back down to 85. You've got to have that 85 per cent vacancy to cater for that inflow. How would you manage that ebb and flow to get it down to 85? Otherwise, you could end up with a system where the pressures just gravitate towards 100 per cent all the time. I'm just curious to know how that would work in practice.

KENDALL BEIN: Sure. Let's accept that there is a degree of ebb and flow. But, in fact, emergency presentations are quite predictable. In fact, things like the matrix system that the ambulances use are designed to smooth that out somewhat. If there is 85 per cent occupancy at an equilibrium state on the wards, that means there are empty beds to go to for admitted patients. We never have a situation where there are more ambulances ramped than there are admitted patients waiting for ward beds in the ED. If those patients were on the ward, then there would be empty ED beds to put those ambulances in; those ambulances would not be ramping. We can cope with our flow in the ED.

The Hon. MARK BUTTIGIEG: So effectively you quarantine 10 per cent or 15 per cent for emergency admissions.

KENDALL BEIN: I really wouldn't use that terminology, specifically because that leads to a catch 22, *Yes, Prime Minister* type situation where if we were to set a KPI of 85 per cent, that would be awful because then we would get calls from the ward, "No, we can't take your patients even though we've got empty beds because then we would break our 85 per cent KPI." As I said, it needs to be an unmandated equilibrium state of the system that the system keeps some beds empty as part of just the way it runs without it having been mandated and therefore not being a KPI. You build a KPI, Goodhart's law says that any measure that becomes a target, ceases to be a good measure, and that would be true of 85 per cent. If you made it a target, it would cease to be a useful thing because we would quarantine empty beds that then wouldn't be used for ED admissions because they have to be quarantined as empty beds to meet a KPI.

If you want to actually produce a system that keeps an 85 per cent occupancy, you need to rebuild the system considering the human factors that are going to promote forward flow. I think that's probably going to involve Prof Mallow's talk about rebalancing elective versus emergent admissions and my points about considering the human factors—actually involving the ward teams with flow, having ward team engagement with flow so that they are building into the way that they manage their patients the idea of empty beds is a good thing and forward flow is an important thing not just for the patients on their ward but the incoming patients that will be their patients or that are still in the emergency department or are still on the ambulance trolleys coming in.

JAMES MALLOWS: Can I add to that answer? You should probably see the 85 per cent as more building in some surge capacity. So, for example, if you had 85 per cent occupancy at 8.00 a.m., you would have an empty ED. We know for a fact that it's a bimodal peak in presentations at the ED, so we get the bus that comes in at about 11 o'clock. We have a big patient surge at 11.00 a.m. and we have a big patient surge at 7.00 p.m., and so obviously those patients that get admitted—and often those patients in the ED are processed and admitted before patients on the ward are able to be processed and discharged. There's a big time difference in terms of when patients present in the morning in the ED and when patients go home from the ward, and so that would build in some kind of surge capacity and maybe you could see the 85 per cent as a floor because, as well, the 85 per cent builds in a capacity.

If you have a really, really busy day and get smashed, maybe you're going to trend up a little bit with the aim to try and get back down to that 85 per cent at a later time in the week because there are variations in presentations—days of the week. They drop off during NRL grand finals and royal weddings; they do go up in other situations. We got smashed by COVID; we got smashed by the floods at Nepean Hospital. The 85 per cent should be seen as some kind of built-in surge capacity to build in so the difference is in processing the ED and the surges that the ED can have and the differences in processing on the wards.

The Hon. EMMA HURST: Dr Bein, just following on from what we've been talking about in regards to these KPIs, I note that in your submission you talked about the fact that too much emphasis on a really specific KPI can have a perverse incentive, and I think that you've just kind of explained quite clearly why that would be the case. Are we currently seeing a situation where there is too much emphasis on those KPIs? How do we kind of re-structure that system to make sure that the focus isn't on the KPIs? Or is it kind of a situation at the moment where it's just almost like a given that the KPIs won't be met and they're sort of almost trivial anyway?

KENDALL BEIN: Which KPIs are you specifically asking about?

The Hon. EMMA HURST: Sorry, I'm talking specifically about the 85 per cent occupancy of hospital beds.

KENDALL BEIN: That's not a KPI at the moment.

The Hon. EMMA HURST: Okay.

KENDALL BEIN: And I would really, really encourage it never to be a KPI for precisely the reasons I've said. I think if it becomes a KPI, it will be a spectacularly perverse incentive and will do terrible, terrible things. I think that the 85 per cent that everybody talks about needs to be, as I said, the equilibrium state of the system that when the system is humming, that's what the number is. Everybody can be aware of it as a useful number. Everyone can be aware that if it's running at this, this keeps it humming; this is an optimal situation.

In fact, again in my submission, the only graph I've got in there—I can't remember which page it's on—shows that less than 85 per cent really doesn't give us much benefit in terms of flow but as soon as you cross that border, you get a sharp decline in your flow. So 85 per cent is just a useful number for everybody to know, but it should be the equilibrium position of a system that wants to be at that number because everybody is on board with the idea of flow.

Ms CATE FAEHRMANN: Can I just jump in in terms of KPI? I think in terms of the KPI question, it would be more in terms of the target, for example, of 90 per cent of patients having to be off-loaded from ambulances within 30 minutes. For example, that's a KPI. What's your view on that?

KENDALL BEIN: What's my view on that? I think that targets like that are useful because they focus people's engagement in what they're targeting. Every time, however, you present a KPI like that, it ceases to be a useful measure of what it's actually measuring. The only way it is going to improve the thing that you actually want to improve is if it's exactly that. If it's a surrogate measure, if there's a difference between what it measures and what you want to improve, then that gap will be exploited to create a better KPI at the expense of, usually, decreasing beyond what you would otherwise see the actual thing that you are trying to improve.

So ETP is another good example of a KPI, and, yes, we do need time targets. Time targets again and again have been established. This is a useful thing, but the ETP time target has now been eroded by the perverse incentives and trying to game the system to get it to the best number without having to improve the system that it's no longer nearly as useful. That's why ACEM is pushing its hospital access targets. It's why you will see in my submission I point out—

The CHAIR: Sorry, doctor, that organisation ACEM or that—

KENDALL BEIN: Sorry, the Australasian College for Emergency Medicine. It's pushing its hospital access targets, which, as I said, I was part of the working group that helped work them out. I think they're good. I think they have some issues as well. I point out some of the issues in my submission and how you might get around some of them, but the thing I suggest also has some issues. There is no perfect way to create a KPI that's not going to be a perverse incentive unless your KPI is exactly what you are looking for; then it'll go hand in hand. What you hope with a KPI is that it'll drag what you're trying to target along with it as you improve the KPI, and that has happened to a degree with ETP. It has happened to a degree with the 90 per cent / 30 minutes. I don't like binary targets. I think that they have a giant loophole that always gets exploited.

JAMES MALLOWS: Can I add to that answer as well? KPIs are good measures of quality, and you need to measure quality to understand how your performance is and to see where the failure is in performance and where you can actually improve. The difficulty is when they become a hard target in preference to other KPIs. That's where you start gaming the system. For example, if you make ambulance off-loads—I'll use that as an example—a hard target, we will focus all of our energies on that but then the 75 per cent of patients that actually present who walk in may get a different level of care. Do you see what I mean? From a personal point of view, ambulance trolleys are really uncomfortable. The 30 minutes is just a random time in terms of performance, but realistically 30 minutes on an ambulance trolley is a long time. A lot of the time we try to off-load due to clinical risk, not understanding that, actually, it's not a pleasant place to be.

The Hon. EMMA HURST: Associate Professor Mallows, your submission recommended an increase in ED staff, particularly senior emergency staff. One thing we heard a lot in our previous inquiry into rural and regional health was the problems around retaining and regaining some of those senior staff members. Do you have any recommendations around what needs to be done from a government point of view to retain and encourage more of that senior emergency staff?

JAMES MALLOWS: Oh, wow. I think it's better to give you more of a Nepean experience, because there's a distinct divide when it comes to staffing of hospitals—not just the number in the map that I've given you but, obviously, doctors want to work close to where they live. There are very different staffing levels in the eastern and northern beaches hospitals than there are out west—stark differences, and that is with numbers and quality and seniority. Some of the inner-city hospitals have a large number of very senior trainees and may not need as many consultant staff, whereas Nepean really struggled. The trainees at Nepean work really hard and do a great job—maybe not as recognised as they should be, but we obviously try to compensate for that by increasing our senior staffing. At Nepean Hospital, we've done certain things with our model that attract senior clinicians to Nepean Hospital. But beyond putting artificial economic incentives there, it's a very difficult question to answer. I said it in a meeting this morning on a different subject, about medical registrars—the vacancies travel west. That's just a stark truth and, to be honest, there is a little bit of "we're used to it", but we are a little bit jealous when we look down the M4.

Ms CATE FAEHRMANN: Associate Professor Mallows, I want to ask for a clarification. Regarding the new ward that was opened at Nepean Hospital, you said that you were disappointed in the uptick that that provided. I think that was your language. Just to be clear, are we talking about a new ward with a particular number of beds that were provided that didn't create the uptick in easing access block, or were the beds not provided in terms of being fully funded and fully staffed? Do you understand my question?

JAMES MALLOWS: Yes, that particular statement related to the new tower that we opened.

Ms CATE FAEHRMANN: New tower—is that what you're saying?

JAMES MALLOWS: Yes, on the hospital campus, we've opened a 14-storey tower with a helicopter pad on the roof. The ED is supposed to move soon; it hasn't. A number of the wards moved across in May, I think, and the tower is futureproofed. There are empty wards that we don't need now that we will be opening in the future, and maybe up until 2030, so it is futureproofed. There are plans for a new tower in stage two, which is again going to futureproof the hospital. But, yes, we got—it's in my submission—a total of eight surgical beds and eight medical beds uplift, and obviously the surgical beds were targeted at elective surgery. That's what disappointed the senior clinicians the most—that we thought we needed more beds than that. Not a lot more, but the fact that we only got an uptick of eight medical beds is what particularly disappointed us. That was staffed beds because, as I said, the tower is actually futureproofed. There are a number of empty wards that will be empty for a number of years.

Ms CATE FAEHRMANN: You're talking about futureproofing, and I'm sure the Government will say the same thing, but every witness to this inquiry has use the word "crisis". We have heard the words "disaster" and "Third World" in what is happening in our hospitals—waits, people dying in corridors and not being able to get the treatment they needed. If there are empty wards, wouldn't it make sense to at least consider more beds now?

JAMES MALLOWS: Yes. Just to give some additional information to that, Nepean Hospital does have a winter bed strategy where we have an uptick in staffing over the winter months. For a variety of reasons it was late being advertised. It got approved in June. Obviously, with all of the problems with staffing and COVID and furloughs and stuff like that, I'm not sure we actually were able to open any of those beds for the winter strategy. I don't want to lump blame inappropriately. There was an attempt to open an extra number of beds to cope with the winter strategy but, again because of recruitment, we couldn't actually fill them. But they were temporary winter strategy beds, so they would have cut out in about October anyway.

Ms CATE FAEHRMANN: Sorry, I'd also ask you questions, Dr Bein, but I don't have any more time.

The Hon. AILEEN MacDONALD: Dr Bein, you mentioned that we need to have a significant paradigm shift and that if there was a simple solution then it would have been done.

KENDALL BEIN: I think so; I think everybody wants to find a solution. I think it's an amazingly complex system that is going to require an equally complex solution that looks at all the moving parts.

The Hon. AILEEN MacDONALD: Noting that there's always resistance to change, how do you start that paradigm shift, and who should start that?

KENDALL BEIN: How do you start it, and who should start it?

The Hon. AILEEN MacDONALD: Yes, or who should be responsible?

KENDALL BEIN: How do you start it? I've given an outline in my submission of an approach; I think that that is probably the approach I can think of that I would recommend. But obviously it needs to be tabled amongst higher powers than me and get appropriate buy-in, because it needs buy-in at every level. Who needs to start it? I think that since the approach at least requires buy-in from the hospital executives—and those hospital executives are not going to be willing to take risks, bear extra expenses and hand over power without something else—it actually needs to come at State level to say, "Look, this is what needs to be approached. We need to trial something; here is an approach."

Let's get a hospital executive who's willing to give something a go—it doesn't have to be my plan if somebody comes up with something better; I just need hospital engagement—and actually be forgiven for when there are inevitably hiccups and slowdowns and the initial teething problems create unforeseen problems. If those are judged by the State as, "Well, everything's immediately failed", rather than judged as, "Right, here is a new part of the problem needing to be overcome", then it's guarenteed to have failed already. Who needs to be involved? Where does it need to start? It needs to start everywhere, but I do think that there needs to be a State level of acceptance that the system needs changing; it needs a large change. Large change is not going to be easy. There needs to be a disproportionate injection of extra resources to get it up and running, with a view to the fact that, at equilibrium, these are the resources we are able to continue to invest in an ongoing and running system.

The Hon. SCOTT FARLOW: Dr Bein, your submission talks about some of the challenges with certain patient cohorts. How much do you think that's taken into consideration at the moment in the different challenges to patients, or is there largely a view that all patients are kept to the same sort of process and rigmarole?

KENDALL BEIN: Clearly every patient has different sets of needs. If we go down to the brass tacks of the access block question, different patients have different needs for different types of beds, which are only

available in differing proportions. At the moment, you can see in the report I tabled, there are long, long waits. It starts off at 74 hours, 24 hours, 110 hours, 27 hours. A lot of these patients are looking for mental health beds in my shop, but it is not universally so. You can see a little bit further down—24 and 26 hours admitted via the operating theatre. Those were patients who were waiting for a bed so that they could actually then go to theatre and would have a post-operative bed ready for them.

So it's not universally just mental health. There is a lot of access block amongst the aged-care component—people needing a specific locked ward bed, so that they don't wander and so that, in a state of dementia or delirium, they're not going to come to undue harm, which is not available for the level of care required on another ward bed like a respiratory ward bed. There are some requiring monitored beds or BiPAP beds or ICU beds. So, yes, there is a variety of difference, and all that's taken into account. A lot of the long waits are because a specific type of bed is not available immediately. A lot of that is mental health beds. Some of that is the access block on the geriatrics ward but some of it is just generic beds.

The CHAIR: Thank you very much. Professor, you had something to add?

JAMES MALLOWS: I didn't want to interrupt the questions from the inquiry, but I just wanted to get back to something about your question about what we are going to do next. It's really an exercise in attitude change. We have to make a decision about what we want to do with the limited resources that we've got. Surgeons, want to do operations, and there are people that should get operations. I see people that come to ED because they don't have operations, if you see what I mean. I just want to put that into the debate: It's not all about ED; it is about a health system. But we do need to have a sophisticated conversation about what we are going to do. Are we doing too many operations? Do we want to prioritise ED flow? Do we need to rejig the balance?

You see at the moment there are debates about tax cuts. I'm not going to take sides, but clearly there are people that feel one side and there are clearly people that feel another side. And at the moment we've just got these tit for tat debates and no-one is actually making a decision about it. That's a bit of a superficial example, but when you look at the health system, no-one has decided how many operations we can actually do, functionally, within our health system to maintain functioning EDs and to avoid ambulance ramping. We just go, "Yes, let's do this number of operations because there are this many people in the waiting list." I think those are the very sophisticated conversations we need to be having. And it ultimately gets down to an element of attitude change and how different stakeholders think about the health system and what we should be doing.

The CHAIR: Professor Mallows and Dr Bein, thank you very much. Your very helpful contribution augments very nicely your submissions. I'm sure there'll be some supplementary questions arising from members having a chance to read *Hansard*. You'd be agreeable that, through the secretariat, we liaise back you with some further questions arising from your evidence today—that would be okay?

JAMES MALLOWS: Yes.

KENDALL BEIN: Yes.

The CHAIR: Once again, thank you both very much. It has been very helpful.

(The witnesses withdrew.)

Ms SOPHIE DYSON, Director, Taylor Fry Pty Ltd, affirmed and examined

Associate Professor GRAHAM REECE, Intensive Care Specialist and Director, Intensive Care, Blacktown Hospital, sworn and examined

The CHAIR: Good afternoon and welcome to you both. Thank you very much for both making the submissions and making yourself available today. I know you're both very busy in your particular roles. To be clear, in relation to your position title, could you state whether you are appearing today in your own capacity or representing an organisation so that we are clear about that?

GRAHAM REECE: I'm here in a personal capacity. I do work as a director of intensive care at Blacktown in the western part of Sydney, predominantly. I've been on the Medical Staff Council for 20 years—half of that I've been on the executive. Also I'm in the State intensive care executive. I'm here in a private capacity.

SOPHIE DYSON: I'm addressing the committee I guess from my dual professional backgrounds as an actuary and a paramedic. The submission was written from Taylor Fry's perspective as a company rather than a peak body of actuaries and data analysts. My paramedic references will be entirely personal.

The CHAIR: As I mentioned in my earlier comments, we are very grateful for the two submissions. Professor Reece, your submissions have been provided to us and processed, and it stands as submission number 22 to the inquiry. It has been uploaded to the inquiry's webpage and forms part of evidence to the inquiry. And Ms Dyson, the same: Thank you very much. The submission has been received and stands as submission number 23 to the inquiry. It has been processed, uploaded to the inquiry's webpage and stands as evidence to the inquiry. So thank you for that as well.

They are both very helpful submissions. Take those as read by Committee members. In terms of your opening statements, which I'll invite you to make shortly, there's no need to quote in detail from the submissions, but set up the key points that you would like to particularly draw our attention to, and that will then will open up our opportunity for questioning. We've got members of the Opposition, the Government and the crossbench, and we'll share the questions between ourselves. We will start with opening statements. Associate Professor, I invite you to make an opening statement if you wish.

GRAHAM REECE: I dropped in something this morning. Have you got that?

The CHAIR: Yes. We are about to distribute that.

GRAHAM REECE: I will wait for that to go out.

The CHAIR: We will happily wait a couple of moments.

GRAHAM REECE: I think both sides are correct. I've been very impressed. We've been working predominantly from Blacktown Hospital with the State Government for a number of years because it's an area with a lot of change and growth in that part of Sydney. The National Health Reform Agreement says that its first primary responsibility is to strive to eliminate differences in health status. We've been very impressed with the way NSW Health has aligned. In the thing that's being handed out to you now, if you want to have a look at page 5, NSW Health has aligned extremely strongly to that vision, which is of equity of outcome as opposed to simply equity of input. Cancer is obviously going to be a major burden, and I put the New South Wales Cancer Plan there on page 5. It very clearly says that their first goal is equity of outcome. It talks about the patient experience, you can see in orange.

Again, the first overriding principle of NSW Health is equity of outcomes. That is a major initiative. We've seen very strong alignment with NSW Health with that over the last couple of years. I think we do have a good health system. Page 10 of the handout was published in the middle of this year from the Australian Institute of Health and Welfare. You can see a significant reduction in mortalities. Cardiovascular disease, cerebrovascular disease and infectious disease—they're dropping significantly in the last 10 or 15 years. There is no doubt that we do have a good health system. There are new challenges. I won't go to them now—youth suicide, elderly people, dementia and the last year of life. So there are challenges. As I heard from the last guy who spoke, there are difficult conversations which we need to have. I have a suggestion where they should be, but that's not what my opening statement is about. So I think that we have a good health system.

One patient will come to hospital. He's patient one and he will say, "I've got chest pain. It's exactly the same as when I blocked my LAD. I had a stent put in at X and Y hospital. Here are my medications and here's the mobile phone of my specialist, who I spoke to half an hour ago, and he expects me in a cath lab in two hours." That's patient one. Patient two says, "I've got this discomfort in the chest." "How long have you had it?" "I got to my GP. He said to come to hospital but I couldn't get to hospital, so I waited for a week to see if it would get

better." That hospital may not have a cardiac catheter lab. He may not have a general practitioner. They're different patients.

We did a review with the Australian Institute of Health Innovation of the best funding models in the world for universal health care. It's by Robyn Clay-Williams and Jeff Braithwaite. The reference is in there and the cover page is there. I'm sure you can find it. It looked at Scandinavian countries, New Zealand and Canada—similar universal health systems. The key findings I put in dot-point form. In the submission that you've got today it is on page 8, which is not labelled but it is clearly the one before page 9, which does have a label. It's the point that in the ED, is staffing the same in every ED? Are the patients coming in the same in every ED? At the back end of the hospital, are there as many consultants rounding in all the hospitals? For early discharge, do all those consultants have rooms close by to the hospital that can be accessed by the patients, or is there a gap which precludes them from being used?

I don't want to go too much into the detail of that in the opening statement, but the point, if you look at slide 29, my second-last point—page 29—the business analysis unit of western Sydney looked at every patient coming to ED for the first nine months in 2020—every ED patient coming—and we looked at their index of relative socio-economic disadvantage or advantage. That explains 84 per cent of the difference in outcome. The business analysis unit looked at the address of every patient and their index of relative socio-economic disadvantage and advantage, which is one of the ABS things it collects every five years. We mapped those coming to the ED. The question was, are they all the same patients? You can see that I've deleted the names of the hospital for this record, but there's Hospital 1, Hospital 2 and Hospital 3, and there's another hospital, Hospital 4, in a different LHD. Forget the number of patients, are the characteristics of the patients the same? In terms of ED bypasses, I heard a little bit of the session the other day about the safe homes. Pre-hospital effects hospital effects post-hospital. What we've been extremely impressed with with NSW Health is that they are looking into the nuances.

The last point I will make in the opening statement relates to a graph on page 4 from the Australian Institute of Health and Welfare. That relates to burden of disease work. You can see that it divides the population using the same thing that I just said, index of relative socio-economic disadvantage into five quintiles of our society—quintile five, the least disadvantaged, down to quintile number one. You can see that the dotted lines on the outside are how long you live. The red non-dotted, or straight, lines are how long you live at being healthy. I think the most difficult discussion that needs to occur is if that is our society—I know that the gross regional product for Blacktown alone is $17 billion. Western Sydney is Australia's third-largest manufacturing area after central Sydney and Melbourne. The point is that if you had to look at your health system as a whole, where would you put your resources in that situation? Do health dollars make a difference? There's an example here—I've taken too long; I'll let Sophie talk—from COVID, where a non-infectious diseases doctor at our hospital worked with community teams, community partners, and at least produced a 50 per cent reduction in the COVID death rate by pre-hospital intervention.

The CHAIR: Thank you very much for that detailed opening statement and specific references to your supplementary document.

SOPHIE DYSON: I mentioned that I'm addressing the Committee from my dual background as actuary and paramedic. I've spent almost 30 years as an actuary and more than 20 working in Australia's health system, providing advice on costing, funding, strategy and operational change, from private insurance to all levels of government across inpatient and out-of-hospital settings. The reason for mentioning that is that I do think this requires a whole-of-system solution. I spent five years in frontline and corporate roles at NSW Ambulance and still do a shift a week on-road as a casual paramedic in south-west Sydney. I mention that because I see firsthand the impact of ambulance ramping.

The terms of reference cover access block, ED performance and ambulance ramping. Ramping is not really a term used by paramedics. I call it bed block or, more formally, transfer of care delays. Access block causes ED delays and overcrowding, which flow on to delays in the paramedic-ED interface. The chain of causation is important because it indicates where the solutions lie. Boosting effective inpatient capacity, either directly or indirectly, by adding new beds, improving patient flow and/or avoiding admissions entirely through better primary and community care—as Dr Bein said in his appearance, it's about creating empty beds, not just adding more beds that will become filled.

The issue is not new in New South Wales or anywhere else. By many metrics, New South Wales is outperforming other States. The papers this morning were full of South Australia's underperformance on ambulance ramping. A lot has already been done by NSW Health in partnership with the Commonwealth. But the fact that we are here today indicates that there is still more to do and also that it's not easy. The solution requires a sustained multifaceted approach across the whole system. Because we're actuaries, our submission talks about

costs and data. It's important to acknowledge that financial incentives and convenience drive both the health care that people seek and the health care that providers offer. We also talk about cost because it's a component of value. Government funding is scarce, and any investment in health needs to offer the best value for money.

Data can help in a number of ways: Linking administrative datasets to see how patients use services and their pathways through the health system, modelling the impact of initiatives and their interactions with the rest of the system, and monitoring program effectiveness. Separately, giving clinicians real-time access to patient clinical information will support the provision of coordinated care across different settings, which is a real challenge at the moment. Our recommendation is not simply "build a model"; it's to use data and modelling to complement getting more immediate stuff done. In that respect I will be focusing on intra-hospital processes and flow, residential aged care and mental health. We don't need to fix it all, just to create enough capacity so that patients can flow through the system more easily. The pandemic has been an exceptionally challenging time for many, but it has also demonstrated how quickly and how effectively the health system can cooperate and innovate. Thank you for the opportunity to appear in front of you this afternoon.

The CHAIR: Thank you very much, Ms Dyson. That's a very precise and clear opening statement. Thank you for that. I'm sure it will generate some questions. We'll start the questioning with the Hon. Mark Buttigieg.

The Hon. MARK BUTTIGIEG: Thank you, Chair. Professor Reece, the conclusion I take from your evidence is that you've got to have a horses for courses approach, depending on a couple of factors. Obviously, in the case of Blacktown, which is your area that you service, you've got exponential population growth coupled with socioeconomic challenges which are feeding into disproportionate demand for health care, and what you're essentially saying is that the concentration of resources isn't proportionately allocated based on that disparity. Is that kind of a rough way of summarising what you're on about?

GRAHAM REECE: Roughly. Can I refer you to page 6 of the new document there?

The Hon. MARK BUTTIGIEG: Sure.

GRAHAM REECE: Again, this is an Australian—Sir Michael Marmot. This is his work, which he presented at the College of Physicians. I am also a general physician. He's an expat Australian. He was chair of the World Health Organization Commission on Social Determinants of Health. On the right are the most privileged, if you like; the most disadvantaged are on the left. Now, the vision which Australia and NSW Health have said is that we have equity of outcome, which is the dark blue line or the dotted blue line up the page. And there is a law called the inverse care law, but we'll forget about that. You can see, just by looking at it, that to get to the blue line, if you are in the more disadvantaged groups, requires a different amount of resources than if you're on the right of the graph. So, if you want to make a difference and you're a health professional, if you want to do 10 hours work and make 20 hours of difference you might work in a certain place.

Of course, you can do research. Well, that's great, because that really is a multiplier effect. That's why I say we've been very impressed with NSW Health, because we've sat down with them, with our hospital executive and with the LHD executive and also with the department—they have recognised that this is the case. I think that they were called, in our hospital, "equity projects". We have run this scheme for about two years, since we've had discussion with NSW Health. I think there maybe have been 20 of these equity projects that, as you've said, they've come from the ground up with support of the executive. So innovation is required. It's got to be guided, as you said, by "What are the problems here?" NSW Health can't say, "Well, they're the problems", because they don't—but they will support these initiatives.

The Hon. MARK BUTTIGIEG: Just on that point though, Professor, presumably this was to some extent predictable, many years ago, given that governments are in the business of predicting demographic trends, socioeconomic status. They have the data harvesting and ability to predict these sorts of things. But what you're saying is that it had to be brought to their attention and now, would it be fair to say, we're playing catch-up, given some of the stories we've heard in those health districts?

GRAHAM REECE: I think COVID was a stress test, in some ways. It was a stress test of: If we go X per cent more, how do we cope? When we met with the department—they've got this information and they are acting on this information. I mean, I'm not a funding expert for NSW Health, but there is funding for this equity. There is equity—it would be a different name. But they also have a bucket of money for socioeconomic disadvantage, if you like to call it that. I guess one thing that we did, which is probably new, we worked with the finance department for one of the universities and actually did a costing study—how much is that? That paper has been published. Tannous is the lead author and it's referenced in these documents. So, no, I think NSW Health was reading these documents. And as clinicians, I think the responsibility—if we're going to talk responsibility—is with us. Often, we became too busy just doing the work.

The Hon. MARK BUTTIGIEG: Sure.

GRAHAM REECE: We have groups called Medical Staff Councils, which I've been on for a number of years. I guess one of our major jobs is to look at the system and to flag to our executive and to flag to the LHD and the department, "What are the issues that need to be done?", which requires thinking beyond myself, beyond my department, beyond my hospital. I think, if anything, we are the ones who are sitting on the bed with these patients—

The Hon. MARK BUTTIGIEG: No, I understand. It's very important to talk to the real people who are actually living and breathing this stuff, 24/7, right across the whole range of portfolios. I want to ask you just one more question before I hand over to my colleague. That mismatch in socioeconomic status and population growth which has increased the demand disproportionately, has the funding increased sufficiently to close the gap going forward?

GRAHAM REECE: Well, there is a gap there today. It would always be nice to be where we've got equal outcome. As I've said, we've reviewed the best in the world and we're confident now, looking at what NSW Health is doing, the value-added approach that they're taking now, that is the best in the world. So, no, I think, as somebody mentioned, I heard this morning, inertia probably—my peers work really hard. All of us would do lots of hours that aren't reimbursed. But I think it is our system and I think it's really up to us. The difficult discussions that were talked about before, we're probably the ones who need to take the time to have those discussions so that people know, because I don't think there is anybody that you talk to who, when you lay the facts out, doesn't see the issues. So I think what's happened is—but no other country is as, I think—you probably saw the COVID modelling that NSW Health did. That was absolutely phenomenal, the number of variables. In fact, I put a chain at the front page of this thing there—a gold chain.

The Hon. MARK BUTTIGIEG: Yes, I was wondering what that was about.

GRAHAM REECE: The gold chain is because the cleaner is so important. If we get multi-resistant organisms—I'm an intensive care director—intensive care units have to close down because there are too many, so imagine what that does to a hospital. So we do have, actually, an excellent health system in New South Wales—gold. It is precious, it is worthwhile, it is world-leading. Our intensive care network is the biggest computerised—the biggest in the world. We are not second, in many ways. But it's like this topic today; ambulance is looking at it from one point of view, the ED can look at if from another, the back of the hospital will look at it another. And really, as we've said, it's actually probably much more complicated than that. So the gold chain means it's something valuable where it's all linked together and there are many aspects to it.

The CHAIR: Just following on from that, I'm trying to appreciate—what seems to be, anyway—a potential tension. Associate Professor, take it that we accept the proposition that your argument is that with respect to clinicians and emergency departments on the ground—I'll use that phrase—have been particularly work-focused on what's immediately in front of them and perhaps, I think using your words, not talking or engaging in terms of the exploration of some of the issues that have been drawn out by this inquiry.

Is it not the fact that, as you've just said, you've got the likes of ambulance, you've got the likes of, for example, we had this morning people talking on behalf of pharmacies and pharmacists in hospitals, this is, obviously, multifaceted and multifactorial, it is inevitable and, in fact, how can it be any other way? But there has got to be that principal driving force from a central point to try and link this all together and get those lateral conversations together to deal with these matters. So no matter how enthusiastic a given group of ED specialists might be and motivated, like yourself, to want to talk and talk in a holistically and, dare I say, broad global fashion, there has to be a driving focus, because at the end of the day that's going to create that ability to articulate and link up these component parts to try to get the synergies we want?

GRAHAM REECE: I think that's very true. There are two points. One is that the population of New South Wales now is different to where it was five years ago. The socio-economics of it are different and all the other inputs are different as well. So we have changed to how we were before. In terms of vehicles for us to escalate this information up to the department, every hospital I think has a clinical council where doctors and nurses sit together with the heads of department and the senior nurses. That is our opportunity to escalate that up.

I can only speak for where I spend most of my time, which is Blacktown Mount Druitt. We have a very active voice and we have an executive who listens very acutely to that. They take our message and convey it to the levels above that in the department. I think there would probably be 30 medical staff councils, but above the medical staff council is just doctors, and we have a certain role. But it is the clinical council, where the allied health people sit and where the head nurses sit and where the patient flow people sit, that is our chance at every hospital to have a voice. And that then feeds in through the structure.

The CHAIR: I won't debate it. But it should feed in is the position that you take, I think. I'm not quite sure whether the evidence we have received necessarily reflects that.

GRAHAM REECE: I can't comment on that.

The Hon. EMMA HURST: I might start with some questions to Ms Dyson. I read through your submission and I noted that access block can be caused by demand factors, supply factors and patient flow. They were the highlights in the submission. Can you expand a little bit more on these factors, just to give us a bit more understanding about the kind of barriers experienced within that process that can lead to the delays for patients that would be ultimately discharged?

SOPHIE DYSON: Sure. In terms of breaking those down, demand is who is coming in the front door. That may be one-quarter of people are coming in by ambulance or 75 per cent that actually come in under their own steam. The demand, I guess, is created—I will preface this by saying that it has been interesting to see different submissions written from different peoples' points of view. I feel very strongly that step one of this process is for everyone to sit down and have a common understanding of the situation and the end-to-end process that we go through here. If you only see something from your own perspective, it's difficult to understand the consequences of your actions. In terms of demand, it's the people coming into ED.

In terms of supply, Dr Bein was talking about the 85 per cent measure as being an appropriate one for capacity. If there is insufficient inpatient capacity and that is exceeded, it slows down the whole process. So that is a kind of supply issue. There is an indirect supply issue if you are talking about where people go once they have left hospital, particularly people who are not able to care for themselves, who might be elderly in residential aged care or have a disability. If there is nowhere for those people to go, they have to stay in hospital and that creates a block. When we talk about flow—again, coming back to Dr Bein's point earlier—it's not about beds; it's about empty beds. It's about being able to move people through the system to free up that capacity. I will just come back to stressing that chain of causation is access block causes ED delays causes the ambulance delays.

GRAHAM REECE: Could I just add on the patient flow business, this even transfer of care that we talked about before—yes, by having hospital meetings twice a day you can focus attention and make that better. For patient flow, let's say you were at hospital A and there is a registrar who has just passed his exams. The Scottish reviewed their health system and they said if you run on a registrar-based system, it will be 70 per cent efficient. If you run on a consultant-based system, it will be 95 per cent efficient. If you are at hospital A, where the consultant does two rounds a week and he is expecting his more junior registrar to make discharge decisions, he will get it right 70 per cent of the time. What that means is that he will send home patients who come back or he will keep in patients who should go home.

You now work at hospital B. Hospital B has a bloke who has come from the UK who has done his fellowship and is just waiting to get on the Australian stuff, so he is a very good junior doctor. The same senior doctor does two rounds a week, but he is so confident in what his junior is saying that those decisions are 90 per cent accurate. If I get a call from my emergency department from the consultant, in five minutes I will accept that patient because what he says is gold. He is like gold. If I get a call from somebody else and what they say is contradictory all the time, I might even ask for more tests. So flow is only a product of high-quality decision-making. That's the point that somebody made before this morning. It's not just getting doctors in these places or senior nurses; it's high-quality decision-making. High-quality decision-making drives flow.

If the real metrics were when was the high-quality decision made, that is the metric. A poor junior can follow a protocol and take six or eight hours to follow a protocol and a senior, who has got practised pattern recognition, can say in five minutes, "Just go from one to 27; don't go the 26 steps in between." To make the system work, how do we get the best doctors spending the most time where they are most needed? I have heard the director-general say that for a decade. Doctors' work-life balance is no different to anybody else. If I can knock off at three o'clock and be home at five o'clock—yes, there are professional reasons, but maybe you also have a family. For work-life balance and how much can you squeeze in, we can all work eight to eight; of course we can. Or eight to nine or eight to 10. People say you have to be a type A personality or whatever to be a doctor or a senior nurse. It doesn't matter. But if we are into sustainability and resilience, many doctors are after some sort of a balance.

Ms CATE FAEHRMANN: I might go straight to questions for Ms Dyson as well. Thank you for your submission. It's very interesting. For those of us who aren't actuaries in this room, which I would assume applies to all members sitting around this Committee table, could you explain a little bit further where you say you encourage government to harness existing linked data assets to explore the impact of different options on access block, ambulance ramping and ED performance? What are some examples of existing linked data assets, in terms of making recommendations to government?

SOPHIE DYSON: Yes, thank you. The issue about using the data is not that we don't have it—we do. We have a lot of data and a lot of administrative data. We have ambulance data. That all forms part of master linkage key for New South Wales. We have inpatient ED data all flowing in there and community outpatient data as well. Also, there is a Lumos dataset, which brings in some of the GP data as well at the Commonwealth level. There are a variety of sources that you can link together to understand the—a complex example of work that is being done in this respect is in Communities and Justice, linking together Health and Education and Communities and Justice data to look at expenditure for different groups of families and the kind of pressures that they are under, whether it's mental health or various characteristics that will indicate whether or not they will need to have higher needs for government services, and actually modelling the impact of interventions and how that will affect their trajectory and the associated cost. This is work that can be done.

Coming back to your question on health specifically, it's not a question of a lack of data and it's not even a question of the lack of technology to do this. The kind of advances in data analytics and techniques over the last few years are astonishing. I think it is really about someone taking responsibility and saying, "Right, we're just going to do this." Health data is a really sensitive area. Everyone is very concerned about privacy—with good reason—and protecting people's privacy and the data not falling into the wrong hands. I think it would take political will from the top to say, "We just need to do this," because we have the capability and the data.

Ms CATE FAEHRMANN: I think one of the very interesting parts of your submission and what analysis like this can provide governments is that kind of savings, if you like, which we have heard from other submissions as well, in terms of investment in preventative care, or you use primary care and what might be the impact on patients, ambulance and ED service and what might be the potential savings from investments in primary care. I don't think we do that. The Government doesn't necessarily do that. As a witness said yesterday, we've got a finite budget; we can only spend so much. You're also recommending then, I assume, that we can't measure in some ways—the Government is not measuring spending in other areas that eases the public hospital expenditure, for example. Is that also what you are saying?

SOPHIE DYSON: Yes, and I acknowledge that it is really difficult. There is talk about investment in primary care is going to yield benefits in the future. You can't say to someone who is lying in resus, "Sorry, love, but in five years time 10 people will be saved." That's why it makes it so difficult to sort of say, "Invest now for benefits later." I think this is a process that needs to happen alongside the just getting stuff done. I think it is identifying across the system where the investment needs to be made and keeping that system-wide view, because with the sort of complexity of funding and provision arrangements between Commonwealth and State governments, it's very easy—the blame game was written 15, 20 years ago. Nothing has changed.

If there are opportunities for another part of the system to take responsibility or to take the cost of that, that's what will happen. I think it's keeping a system-wide view, thinking about the future, thinking about interactions and also thinking about substitution. I raised in my submission, I guess, the point that if you send an ambulance to something, that's about $1,000—broadly. If someone goes to the ED, it's about $600 to $700 depending on whether they're admitted or not. If they go to their GP, it's much less. So it's a question of where that care can be provided most effectively and most efficiently.

The Hon. LOU AMATO: Cate asked a very good question. I was going to ask that one, but to go a little bit more, Ms Dyson, using your VicHealth system data—I understand you only just commenced evaluation of the New South Wales Government's End of Life and Palliative Care Framework 2019-2024. Do you know when that will be completed?

SOPHIE DYSON: I think we've got a fair way to go in that. I'm not actually part of that team working on that engagement, so I can't give you exact details. But if you would like to know, I'm happy to come back to you with a time frame later. I'll take it on notice.

The Hon. LOU AMATO: If you could, I'd really appreciate it.

The Hon. SCOTT FARLOW: I'd like to thank both witnesses for your evidence here today and your submissions and detailed subsequent submissions as well. Ms Dyson, I think one of the comments that stuck out to me from your evidence earlier was that everybody comes to this effectively with their own perspective and it's an ability for us to sort of stand back—and I guess this Committee, in looking at this, to stand back—and try to work out how everyone's perspective works into the entire system. What sort of mechanisms do you see that we could best take that approach to be able to pick up all of those little cogs in the wheel—whether they be the pharmacists this morning or whether they be surgeons in western Sydney—and distil that to work out how we get to the end game of being able to alleviate this issue?

SOPHIE DYSON: I think get everyone in a room, either actually or virtually, and just sort of say, "Step me through what you do. What do you think the influences on your workload are and what do you think the impact

of what you do has on the rest of the system?" Just get that perspective and just literally step it through. I was talking to a friend of mine who's a specialist and he was sort of talking about hospital flow processes and the need for more senior clinicians to be involved in decision-making. From his perspective, he was saying, "When things get really busy, ED just kind of admit people to get rid of them." And actually not having that specialty involved in the admission means that you end up with people in beds who then need to be discharged. That doesn't happen instantly, so you're actually just perpetuating the problem by not, I guess, understanding the consequences of that action that you've taken.

The Hon. SCOTT FARLOW: I take from your opening statements where you said that New South Wales in comparison to other States was doing well, but of course the fact that we're here today shows that there's a lot more to be done. Just stepping back from that, I'm wondering is there anything we can learn from approaches being taken in other States or is there anything we can learn from approaches being taken internationally or is this something where we really need to go back and look at first principles to work out a solution?

SOPHIE DYSON: I don't think we need to look at first principles. I think that there are elements of a solution in place, and I think if you were looking—I see the initiatives that NSW Health has put in place. I see the kind of level of capacity that the hospitals are working at, and you sort of think, "Right now, you just need some breathing space." And that's why sort of in the short term, I mentioned in my opening statement, I will be looking at sort of aged care and mental health because—and again, check, is my perception real? But use the data—

The Hon. SCOTT FARLOW: Mind you, we've had other witnesses that have said exactly the same thing today, so that sort of corroborates your evidence.

SOPHIE DYSON: But I think use the data to say, "Where is the problem?" As Associate Professor Reece pointed out, it's not the same everywhere; it's horses for courses. But work out a couple of areas where what's something that you do is going to have bang for buck. It's going to affect a big enough cohort of patients that you can actually just ease that capacity and then start planning for the longer term. As an example, with residential aged care, you've already got infrastructure there. Everyone's in a hospital bed. There's nursing staff there. There are all the outreach programs in place, and actually making a decision about what should and shouldn't be transferred to hospital and delivering more of that care within the aged-care environment would free up, I think, of the kind of breathing space that you're looking for, some of that capacity.

In terms of initiatives from elsewhere, something non-clinical that I see as a paramedic going to residential aged-care facilities, you frequently get there and the patient says, "I don't want to go to hospital." Then you ask for the advanced care plan and it says, "Not for transfer to hospital. Not for fluids. Not for this or that," and you say, "Well, why are we taking them?" "Yes, that's fine. The son just wants them to go." Okay, but what do they want? We don't respect or listen to elderly people enough. We write it off because they have cognitive decline. I think it's perfectly possible to be experiencing cognitive decline and still be absolutely clear that you don't want to go to hospital.

I think one step that could be taken from an administrative perspective would be to have a standard approach to care planning. There is no one form. For advanced care directive, there's no one sort of approach to producing that, so it's actually really difficult to have a piece of paper and say, "Yes, this matters. I can count on this."

In the UK they have something called a ReSPECT form, which is a really standardised way of documenting your wishes, and everyone follows it. But it also gives the patient, at any point, the freedom to make their own decisions contrary to that.

The Hon. SCOTT FARLOW: Thank you very much, Ms Dyson. Associate Professor Reece, when we were talking through the examples before, I thought they showed a really good point—how you could have exactly the same system in place but the quality of an individual may be a variable in what is required—so your 75 per cent example and your 95 per cent example in what sort of information you're getting. What do you see that we can do to improve the consistency or to change those processes so that there can be more consistency across the system?

GRAHAM REECE: I think—

The Hon. SCOTT FARLOW: And is it even possible, I guess, in a sense?

GRAHAM REECE: The practice of medicine and nursing, and I'd imagine allied health and pharmacy is a bit like it—sometimes it is caught. So to have the best leaders working in the areas of most need, because you then become a role model. And it's what you say, but it's also what you do. I think that if we could look at the staffing structure at the hospitals in this State where there is a longer period of times kept healthy—look at that structure. And, at least, if you can't replicate that structure in the hospitals whose outcomes aren't as good, the

doctors must be unbelievable if they are going to have a better—if the best doctors get those results in the best hospitals, how can other doctors, in less-resourced hospitals, come up with the same results? It is tricky.

Could I make another couple of points? The Hon. Mark Buttigieg asked about the linkage between socio-economic status or the index of relative socio-economic disadvantage and funding. I think that that actually has gone up to the national committee, IHPA, for reconsideration from NSW Health. I think that that point has been raised. There is funding associated—

The Hon. MARK BUTTIGIEG: Sorry, Doctor, can you elaborate on the national committee?

GRAHAM REECE: There is an independent hospital pricing authority—IHPA. It looks at weightings and cost of production, if you like. This patient says, "I've responded to that treatment; I feel better," on day two. Another patient may take a couple of days to work it out, so the costs of production are different. You've got to pay a staff a bit more because they're locums. And if they are a locum, are they used to the intricacies of your system, or are they not used to the intricacies? In other words, the cost of production differs, and that's what NSW Health, I think, have now taken to the national body, flagging it. That was in answer to that question.

The CHAIR: Sorry to cut you off. Can you be very quick with the final point you are going to be making?

GRAHAM REECE: The last one is very quick. What to do? Louise Markus is the chair of the Australian Institute of Health and Welfare. Those documents are phenomenal, and most of our planning in western Sydney comes from those documents. I think we have committees and can get people together in a room, with deference to Sophie, but we have got committees meeting already. If this could be part of the business as usual, then those committees are value-adding.

And I think every medical staff council and clinical council should read the IHW documents. A lot of the stuff coming out of our own New South Wales—BHI: tremendous information. I think, really, if each hospital and LHD responded to those documents saying, "This is how it affects us. What am I going to do about the youth suicide stuff? And if my LHD has got a lot of cancer patients, what are we going to do? I'm not going to do liver transplants at Blacktown, because the State doesn't need another centre." That way you can fit your own little niche into the global.

The CHAIR: Thank you both very much. It has been wonderful to hear from you. Thank you for bringing a huge amount of expertise to the table, which has been added very nicely to the submissions. There may be some supplementary questions arising from your evidence, and the Committee secretariat will liaise with you. Thank you.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms SUSAN PEARCE, Secretary, NSW Health, sworn and examined

Mr MATTHEW DALY, Deputy Secretary, Patient Experience and System Performance, NSW Health, sworn and examined

Dr DOMINIC MORGAN, Commissioner and Chief Executive, NSW Ambulance, affirmed and examined

The CHAIR: We will get underway. Thank you to the Government and, particularly, our most senior witnesses for coming this afternoon for what is our last session of the second and final day of the inquiry. As I indicated off record before we started, Government members have been generous enough—subject to perhaps needing to tidy up something at the end—to cede what is their half-hour, effectively, leaving then just half an hour for the Opposition and half an hour for the crossbench, which means we'll have an early mark, if at all possible. We will share the questions, therefore, between the Opposition and the crossbench. Thank you all once again for coming along.

I will start with my first question to the secretary. It is regarding a piece of evidence from Wednesday. I have to say, it's a complimentary piece of evidence directed to you quite specifically, Secretary. It's from Mr Gerard Hayes from the Health Services Union, with him reflecting on the matter of what's being termed "ambulance ramping" for the purposes of this inquiry. I guess it's the broader vernacular, "ambulance ramping". Mr Hayes says on page 46 of the uncorrected *Hansard*—you may not be aware of this, but I will draw it to your attention because I think it's important to reflect on this. It's page 46, at just about a quarter of the way down, and I will read part of the quote. He is talking about the issue of the ramping. He says:

> 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.

That's what he says. Then he goes on to say:

> Health has been under stress for the last two years.

He makes that comment—in fact, more than that, really. It's pushing two and a half, going on. Health was under stress before the last two, 2½ years. He goes on to say—and this is a repeat of an earlier statement:

> 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—

I'll leave that aside for the moment—

> it's a hard job.

So there's a recognition that it's difficult; that ramping has been an issue. But if you read the rest of his comment he, in fact, is complimentary that you obviously were charged—apparently back in 2016—in a previous role to, dare I say, take the bull by the horns and try to tackle this. The evidence from Mr Hayes was—I am paraphrasing him—that some improvement was actually manifested and there seemed to be some progress actually made. That's a demonstration—and this was his implication from his further comments—that we were able to make inroads into this. To see it in its full continuity, obviously the focus is on the emergency departments but also the ambulances not being able to bring people into the emergency departments as they are, as we say vernacularly, "ramped". Then, obviously, there is the bed block access. It seemed that back then there was something able to be done, whatever was brought to bear. I'm just wondering, because I'm actually quite interested: What were you able to do to help tackle it back then?

SUSAN PEARCE: Thank you, Mr Donnelly. I appreciate those comments. It was actually 2015.

The CHAIR: It was 2015? Okay.

SUSAN PEARCE: It was a year earlier, when I was formerly the Chief Nursing and Midwifery Officer for New South Wales prior to being the deputy secretary, that I was asked to assist with a situation that had evolved during that time where we were seeing some extended delays for ambulance patients being able to be off-loaded in our emergency departments. Indeed, it had been a problem in the State for probably well before that time. It had been coming for a while, I guess is the point. Back in the late 2000s, I was a director of operations at one of the local health district area health services, and certainly we were experiencing challenges then. In 2015 we had a well-documented case of a lady who had waited for several hours for an ambulance to come. I guess it was the culmination of, as I've said, a number of years of challenges, although these things ebb and flow with seasons and the like.

We found that, as a system, to be unacceptable and we took very strong action. Now, the performance that we managed to achieve has been sustained, and was sustained at that time, for years. It wasn't a flash-in-the-

pan effort; it was an effort for us as a whole-of-system. This is a complex issue, and I need to be clear about that. Health system flow is complex. It's not simple, and it's not transactional. It involves so many different balancing items. But the most important balancing item for us was that we had to balance the occupancy of our hospitals against an ambulance service that needed to be able to respond to 000 jobs. With the permission of that lady's family, we used her story to talk to our staff about what we think is acceptable and not acceptable in our system. Yes, we have KPIs and we have measures for all sorts of things, but actually that is something that we have never focused on here because that should be the end product, not the starting point.

What we did, to be honest with you, on one level was quite straightforward. That was that at a Ministry of Health level we took a very serious interest in this day and night, seven days a week, and we've done that ever since 2015. That focus has never ever stopped. We have people 24/7 monitoring this across our system and working very closely with the ambulance service. But the main balancing item for us was to make sure, as I said, that ambulance paramedics could respond to jobs and not be caught and delayed in our emergency departments. Now, I'm not saying that we don't have delays and that we don't have issues; we do. Like every other health system in the country—and, in fact, the world—we are challenged by these issues. But we commenced by having teleconferences with chief executives, seven days a week, across the metropolitan area. Those teleconferences also included the ambulance service and our non-emergency patient transport service to bring us all together to work out where we may have issues and what we could do collectively to resolve them.

We also have excellent datasets. As you know, and as I think I've said in these committees before, I am a health professional. My fundamental being and the reason I come to work every day is for patients. What we wanted to focus on was how we could make this better for patients, and we did make it better. We also had a phenomena called ambulance release teams that had been put in the State some years prior to that. I think they'd been in place for about 10 years by that stage, probably from about 2005 or 2006, which were designed to basically relieve paramedics to get back out on the road. But, really, all they were was a bandaid to an underlying issue. Because of the work that we did as a system, I was able to remove that phenomena in March or April 2016, and we have never even looked like replacing it.

The one thing I will say, if I may, is that despite the challenges that we have as a health system—and I do want to acknowledge that we do have challenges—we are regarded as the best health system in the country, and we are one of the best health systems in the world. We have had a number of other States and other jurisdictions come to visit with us, even this week, to understand from us how we manage the way we do because, despite the issues that COVID has presented—and, of course, furloughing of staff and flu this year and various other things—we have still managed to achieve results for our patients that are better than everywhere else.

The CHAIR: Forgive me, but perhaps I was not as clear as I could have been. Mr Hayes noted and, in his own way, was complimentary about the fact that there had been that kick-up, that so-called improvement in 2015, 2016. He was prepared to put that; he's a straight shooter. But, equally, very clearly he makes the point that there's been a deterioration, quite a significant deterioration. This is pre-COVID as well, so it's not just a matter of, commencing in 2020, that there was an improvement in things, as he sees it, but then that was relatively short lived—they're my words, not his. It seemed to be improved for a couple of years or maybe a couple of half-years but there has been deterioration ever since.

SUSAN PEARCE: Mr Donnelly, certainly the submission that NSW Health has made to this inquiry will tell you pretty plainly that it wasn't sustained for a couple of years or a couple of half-years. That performance uplift from August or September of 2015 was sustained really right the way through until 2019, so probably about four years where we really had, other than the winter periods, 2017—

The CHAIR: We understand the cyclical nature. You're saying it's 2019?

SUSAN PEARCE: In 2019 what we started to see—if you look at our submission, you will see that you see a direct correlation between an increase in emergency department presentations and a slight decrease but not a terrible decrease, a slight decrease in performance, so the two go together. What you can then see from our submission very clearly is that when COVID commenced—and I'm not attributing all of this to COVID, by the way. The health system has continued to manage this over a number of years. But COVID has had a direct impact.

The CHAIR: There's no contest over that. We're not cavilling with that particular point.

SUSAN PEARCE: I guess one other thing I would say is that, if you remember—and it feels like a lifetime ago—back to 2020 when we had the first very significant lockdown of the State, our emergency department attendances reduced very significantly, down by about 30 per cent during that period. Our performance correspondingly went very significantly up. So there's obviously a direct correlation between those issues.

The CHAIR: Perhaps we need to move on because we obviously probably seem to agree to disagree in terms of his reflections and the deterioration that he asserts versus the time line that you've described—

SUSAN PEARCE: Our data's publicly available, and I think it speaks for itself.

The CHAIR: It's there, and you, presumably, from what you're saying, stand by that. I might move to the Hon. Mark Buttigieg, who's got some questions, and return to myself. We'll just progress.

The Hon. MARK BUTTIGIEG: Can I just quickly follow up on that from my colleague's line of questioning? Secretary, with that 2019 deterioration which you just touched on, so we had about four years of relative success, was there any systemic change that correlated with that 2019 deterioration in performance? Or are you saying the same systems were in place, it is just what it is?

SUSAN PEARCE: Can I just be clear about the contextualisation of the deterioration in performance?

The Hon. MARK BUTTIGIEG: Yes.

SUSAN PEARCE: Because, to be very clear, we're talking about five percentage points.

The Hon. MARK BUTTIGIEG: Right.

SUSAN PEARCE: Right. So we're not plummeting by 20 per cent or 30 per cent. The transfer of care indicator—this is for transfer of ambulance patients, as I'm sure you've heard, to emergency departments—is 90 per cent within 30 minutes. In that winter of 2019, which was again a bit of a challenging winter, it probably looks like it's down at about 85 per cent. But there is also a correlation between that and an increase in emergency department attendances. I think that's really important to note. Our current performance, which is somewhat lower than that, has absolutely been a direct impact of the COVID pandemic. There is no doubt about that.

The Hon. MARK BUTTIGIEG: Is it the position of the department—because I want to move on to some other testimony here—that, allowing for the aberration, and it was one hell of an aberration, of COVID, in a systemic sense things should return to a steady state at somewhat of an acceptable level over the next year or so? Because the systems haven't changed, COVID's gone and everything was okay from 2015, 2016, and we should continue on that trajectory. Is that the contention?

SUSAN PEARCE: COVID is still with us, as we know. We've got just under 1,000 COVID patients in hospital at the moment. That's the first time we've been under 1,000 since New Year's Eve. It's pleasing to see those numbers reducing. Could I just acknowledge, though, that these results cannot be achieved without the hard work of the staff of the New South Wales health system and the ambulance service. What we are starting to see, pleasingly, are some green shoots of improvement in performance. Just this morning, when I was looking at our transfer of care performance, we're just under the target of 90 per cent today.

We haven't been seeing that sort of performance for quite a while, so it's been really pleasing over these last few weeks to start to see that lifting. We'd like to think that we will be coming through and starting to see some improvement. The other thing to note, of course, is that the number of furloughed workers has reduced very substantially. We're talking about a few hundred now this week, compared to, at its peak back in January, 6,000 furloughed staff in one day. That's in addition to normal sick leave and other leave arrangements. So there are things that are starting to shift in the system that we hope will give our staff some relief from the unrelenting pressure of the pandemic that we've experienced over these last few years.

The Hon. MARK BUTTIGIEG: I'm taking it that is the sort of picture that the Minister's getting, because we heard on evidence on Wednesday—these are emblematic examples, but I don't think they're anecdotal. I think if you talk to enough people you get quite consistent evidence to this effect. This was Mr James Tadros on Wednesday. I'm reading from *Hansard*:

> 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. … "

I think the Minister's response was, "That's ridiculous." Then you go to the testimony of a nurse, Kelly Falconer, on the same day—I'm just going to selectively quote here because it's quite lengthy—who says:

> … 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 …

On questioning this morning I think the response I had from ASMOF was that there were very limited, if any, fatigue management policies in place. What's the response to those anecdotes? As I say, I think they're not just one-off anecdotes. If you talk to enough people, this will be quite a common experience. The Minister was quite dismissive of it in a response in the media the other day, which is somewhat of a concern, I think.

SUSAN PEARCE: The first thing I would say is for any patient who doesn't get the care that we would like them to have, we can only ever unreservedly apologise for that. It is absolutely the last thing we want, for

people not to have a good experience when they come to our hospitals. In terms of our staff, I think we've certainly acknowledged before and I have acknowledged publicly on many occasions the pressure that the staff of the New South Wales health system have been under. I'm not attributing that entirely to COVID but clearly the pandemic has exacerbated those issues for our staff and, in particular, some of our very busy hospitals.

We want our staff to be well supported and cared for—absolutely no question of it. Fatigue management has been incredibly difficult. It's something we're actively talking to our chief executives about all of the time, because people need to be able to get off and have leave. That has been very difficult, obviously, as I said, when you've had 6,000 staff furloughed at one time and people working really hard to keep our health system going the way it has. It is thanks to them. This is the same State health system that managed through a pandemic in a way that many others weren't able to. That is thanks to our staff and the efforts that they put in.

We've been fortunate to have some investment in workforce this year, of course. We're very keen to make sure staff are given leave as soon as absolutely possible. So we're very busily recruiting. I'm pleased to say that so far, since 1 July, our active ads for jobs are up by about 20 per cent against the same time last year. That's good to see because it's very important that we get people into our workforce as quickly as we possibly can. We've got a very good number of newly graduated registered nurses and midwives starting in 2023. I think it'll be our highest year ever. So around 3,700 newly graduated nurses and midwives in the pipeline is really strong there, which is great. But it's very important that we support those less experienced staff, and to do that, we need to support our more experienced staff. We are focused on that.

The CHAIR: Could I just quickly jump in. If you take, for example, the point you're just making but then look at Blacktown Hospital where, since December 2021, approximately 20 experienced emergency department nurses have gone. They're gone; they've left. And this is a theme we're hearing time and time again. In the member's example from the very experienced nurse from northern New South Wales was saying, they're just leaving. They are at the point of not approaching a breaking point, they're broken; they're leaving. I appreciate the points you're making about the advertising and all of that, and that's very good, but this is happening in real time now. These people are hitting the wall now. What's being done to deal with it now? I appreciate that there are all sorts of challenges, but these people are bleeding out of the system—very experienced people.

SUSAN PEARCE: Look, Mr Donnelly, I think Mr Minns gave evidence at the estimates hearing around the range of workforce measures that have been put in place. I'm not saying that this has—it takes time for those things to take effect, and I do appreciate that for some staff, they have felt that they want to do something different. I think that's, again, a phenomena that is being experienced not just in New South Wales but it's a worldwide issue with health staff. We saw a report yesterday around skills shortages. Registered nurses are at the top of that list. This, again, is not peculiar to this State. What we are trying to do, as I said, is to invest money so that people can get off and take leave and be replaced with additional staff because I think that's important. Clearly we've got to recruit for those staff. We're out there doing that. There is no shortage of effort to recruit people.

The CHAIR: Sorry, not to cut you off, but they don't want a change. They actually use words like they love their work. They treat it as a vocation. They would rather do nothing else but do this work, but they have literally hit the brick wall. They don't want to leave. They would love to stay, but it's just beyond human coping.

SUSAN PEARCE: Mr Donnelly, we still have a very, very large health workforce. I think that ought to be noticed as well. For anybody who's made that decision, we obviously encourage them to come back to us. We're doing every conceivable thing to improve what we have available for our staff in our workplaces. I just can't state that strongly enough.

The CHAIR: Can I just say to you again, at Prince of Wales Hospital 32 emergency department staff have resigned this year. That's quite a cohort of lost experienced emergency department staff from one obviously large and very important facility, one hospital.

SUSAN PEARCE: Mr Donnelly, without knowing what the usual rate of attrition from that department is, it's hard for me to comment. The workforce in health is not static. People do come and go. But, as I say, we are aware of the phenomena, and the COVID pandemic has certainly exacerbated how people feel about their work and wanting to continue to do it at least for now. What we can do going forward, though, is to continue to recruit. What we've got to do for our health system—and this is not about painting a rosier picture or to sugar-coat anything—is be cognisant that if we want people to come and join our health system and we keep talking about how terrible it is, that makes life quite difficult.

We want people to come and work in the New South Wales health system because it is the best health system in the country, if not the world, and we do genuinely believe that. Is it perfect? No, it's not. But we are actively recruiting for staff. As I said, the number of new graduate nurses that have applied for jobs in New South

Wales next year probably exceeds even what we thought we would get. There are people wanting to come and work for us. We've got to make sure they're adequately supported. That's our job and that's what we intend to do.

The CHAIR: Let me put it another way. Can you tell the inquiry this afternoon—and I'll just use this figure; I'll just pull it out of the air, so to speak—what are the three most important initiatives right here, right now in place by NSW Health to deal with this extraordinary challenge we have in our emergency departments?

SUSAN PEARCE: I think, again, to be clear—and I've heard your question about the three most important initiatives. I think emergency departments—and one of the things that New South Wales has successfully done over the years, we treat it as a whole of hospital. Our emergency department staff face a lot. They have limited control about what comes through the doors of an emergency department, whether walking through or by ambulance. We focus on our whole hospital because our emergency department staff need to understand clearly from us that this is not all resting on their shoulders. So the critical issue for us, as I said, is funding to help support the workforce, attraction, recruitment, retention. So you know we've got funding to enable us to attract and retain people in hard-to-fill roles that we've been working through and identifying with our local health districts. The recruitment of the additional staff but, very importantly, the support of the staff that we have got—and that just cannot be understated. There are also efforts underway as to how we can support staff in rural communities who are—we need to be able to recruit all manner of staff into the health system and we need to make sure they're adequately supported.

The CHAIR: Ms Pearce, let me make it easier, then. Let's go from three. Can you tell me and tell the Committee this afternoon two initiatives specifically in place by NSW Health to deal with this extraordinarily problematic situation we have with our emergency departments?

SUSAN PEARCE: I think I just answered that question, Mr Donnelly. I've talked about the initiatives. We've got additional funding to recruit thousands of extra staff. We're doing that, so that's one. Obviously the ambulance service has got initiatives with regard to its paramedic workforce, which are another very important component. The second issue I spoke to you about was the attraction, recruitment and retention package to attract health professionals into areas that have been traditionally hard to fill. This is not just about emergency departments. They do not sit in isolation to the rest of the hospital.

The CHAIR: I think it's fair to say this Committee is acutely aware of that reality.

The Hon. MARK BUTTIGIEG: Could I just explore something, Secretary, in terms of the department's awareness of, I suppose to put it in crude terms, bang for buck? My understanding is that about one-third of the State budget is directed towards health, and then we heard this morning on evidence and we've seen in submissions that 55 per cent of health is contributed to by the Federal Government—NDIS, aged care—and then 45 per cent by the State. Has there been any jurisdictional comparisons of the amount of percentages of budgets that get spent on the New South Wales system compared to elsewhere? Because it seems to me like if you've got such a large proportion of budget dedicated to one sector—and rightly so; health is the most important thing we've got—then are we getting value for money compared to other jurisdictions. For example, you made the statement that you thought we were world leading. Are there comparisons in terms of what we're getting for our money? Is one-third of the budget unusually high for a jurisdictional comparison or is it an acceptable standard? Do we have any analysis on that?

SUSAN PEARCE: We do. I don't have it in front of me right now, but we certainly do and we could provide you on notice some more specific information than what I'm about to say. Certainly we have had data historically that compares Australia—and New South Wales, in fact—to other jurisdictions, so outside of the country. So as a percentage of spending, the Australian health system tends to hold up very well and have better outcomes. If you compare us, for example, to the US, they spend far more on health and have poorer outcomes.

The Hon. MARK BUTTIGIEG: Far more not in absolute terms, presumably, but in percentage of the budget?

SUSAN PEARCE: Yes, very significantly.

The Hon. MARK BUTTIGIEG: The US might not be a great threshold comparison.

SUSAN PEARCE: Maybe not, but we hold up even if you—

The Hon. MARK BUTTIGIEG: What about northern Europe?

SUSAN PEARCE: Yes, even if you compare us to—countries like Norway and Denmark perform very well. They're very efficient and have very good health outcomes, and Australia is right up there with those countries. The UK, I think it's fair to say, even compared to them—they have different arrangements around primary care, which I think is another important part of this whole situation, but we do stand up very well. In

response to your question, it's not unusual to have a large amount of public spending on a health system. But in terms of bang for buck, as you've put it, we perform very well and have very good outcomes.

The Hon. MARK BUTTIGIEG: I note that the secretary of the HSU, Mr Hayes, is calling for a royal commission to address issues like that. Given what you've just said, do you think there's validity or merit in that?

SUSAN PEARCE: It's really for Mr Hayes to comment about his desire to have a royal commission into health spending. I know that he's been quite vocal about that, and I understand that he's looking at that and talking to various people.

The Hon. MARK BUTTIGIEG: On the question of NDIS and aged-care patients taking up beds, do we have any stats on the percentage of that?

SUSAN PEARCE: Yes, and I think I also gave evidence on this at our recent estimates hearing. It's fair to say we're working closely with the Commonwealth on both of those issues. We're starting to have some more productive discussions, which is really good. The last figures that I saw, we have around 1,000 NDIS and/or aged-care patient types in our hospitals across the State. Of that number, there were just over 600 who were beyond their expected date of discharge. That's quite a significant number of people occupying hospital beds, but it's our job to care for them. To be clear, I don't want that to be read as we're denigrating those people or being disrespectful or uncaring. It's just that they've been medically cleared for discharge and we're unable to discharge them. There are various groups that are meeting at a State and Commonwealth level to talk about that very issue, and the Commonwealth Government has been quite vocal. Minister Shorten attended a health Ministers' meeting not long ago to talk very clearly about the improvements that he would like to see in the NDIS, and we're very encouraged by that, and certainly we're having very active discussions with the Commonwealth about primary care.

The Hon. EMMA HURST: The Chair was asking questions before around recruitment, and Ms Pearce was talking about the recruitment efforts that are currently underway. The Government's investment was fairly recent, only in June, to recruit another over 10,000 full-time staff. Will you give an update on how that recruitment is going and if there's a time frame around those roles?

SUSAN PEARCE: Again, I'll need to refer you back to the comments that Mr Minns made at the estimates hearing. Certainly he was able to go into quite a bit of detail around those. The time frame for us in this financial year, 2022-23, is of that 10,000 number there were just under 7,700 staff within that number, and so there was funding to support that. As I said, the information that I've been provided is that as at—I'm not sure if it's the end of August or September, we're 20 per cent up on our advertising efforts compared to the same time last year, which is important. That's requisitions that have gone into the system to recruit to roles, and so obviously that additional funding is supporting that. I'm not sure if Dr Morgan is able to comment about the paramedic enhancements, because that was quite a large proportion of that number as well.

DOMINIC MORGAN: Thank you, secretary. Yes, Ambulance was provided funding for 2,128 additional staff over the next four years. During the pandemic we had recruited already 338 additional people that this provided funding for us to maintain, so those 338 are already on the books, and since 1 July we've put on another 292. Only in the last couple of weeks, we've just closed graduate recruitment for those paramedics who will be graduating university by the end of the year. We've had more than 840 applications from those people, so we're in a very good spot in terms of meeting our targets.

The Hon. EMMA HURST: Ms Pearce mentioned there was an increase in advertising, and Dr Morgan was able to give quite a specific number of applicants. Some of the evidence that we've heard in this inquiry is that it's just so difficult to fill some of those senior roles once people have left. Are you still seeing that that increase in advertising is able to actually recruit some of those senior roles—particularly in some of the hospitals where we're hearing that it's even more difficult, such as western Sydney and other places like that? Are we seeing an outcome from that increase in advertisements?

SUSAN PEARCE: I think the point of your question, Ms Hurst, is if we're attracting more experienced staff. I'd have to take that on notice in terms of the years of experience, if you like, if that's possible. The one thing I would say about that, though, which is an important thing to note—we do see more experienced staff retire or resign in normal circumstances, let alone the circumstances that our staff have endured over these years. When I was the chief nursing and midwifery officer, one of the things that I needed to work really closely with the system about was we just need to be careful about how we characterise the recruitment of staff.

The issue is that sometimes we keep trying to recruit more experienced staff and they're just not there. That's not a failing; it's just a fact. We have a lot of really excellent less experienced staff that we recruit every year. Our job is to then support them into the workplace, and so it's really important that we look at it in that way. We've invested over the years—I think in the last 10 years we've increased our clinical nurse educators by about

50 per cent, so there's been a significant increase in clinical nurse educators to support less experienced staff. There are parts of the health system you talk about, and there's always a knock-on effect in other areas. One of the clear issues for me, as I said—and I'm going back a few years now—really was that we needed to stop just focusing on trying to recruit more experienced staff if they weren't there. Recruit, perhaps, some less experienced staff, but make sure that they are adequately supported in the workplace.

The Hon. EMMA HURST: This kind of fits in with your answer and flows onto some of the questions that the Chair asked. Obviously there are the recruitment issues, but one thing that came up a lot was the strategies that need to be worked on to support workers and improve their working conditions so that we retain workers, or even re-attract people who are wanting to work in this space but have burnt out. How do we regain those people back in? Are strategies being deployed by NSW Health specifically for that retention of staff and improvement of workplace, and even helping experienced people who have left but haven't necessarily retired to get back into the system?

SUSAN PEARCE: Yes, one of the things that we were able to continue to do during the course of the pandemic, and we'd started it prior to—you may be aware we've been very focused on patient experience here in New South Wales for a long time. To improve that, you need to improve the experience of staff. We have a chief experience officer, Dr Anne Marie Hadley, who has been working with us now for quite a few years. One of the pieces of work that she was able to complete during the pandemic has been *Elevating the Human Experience* guide to action. We've got a lot of engagement with staff around that and people who are invested—simple things like "Kindness works here"—because it's important for us to get the people who come to work every day with that attitude, to encourage more people to come to work every day with that attitude. I think the great majority of our staff do.

That's just one example of the work that we have done, because we absolutely do recognise that if you're going to improve how patients feel about the care they've received, you've really got to improve that for staff. This is in addition to the investment to try and recruit more staff and to allow people to go and take a well-deserved break. I don't think we can underestimate the impact that not having proper leave has had on staff in health systems in all jurisdictions and on all of us who have worked now for a very long time with very limited periods of leave. It's certainly not something that we want to see continue, so it's important that we arrest that trend very quickly.

The Hon. EMMA HURST: Yes. On that point, I note that in the submission it said that there's a plan to decrease employee excessive leave balances. Does that mean that employees will be forced into annual leave? How is that going to work in practice?

SUSAN PEARCE: There are already arrangements in place with regard to annual leave when you get to a certain point where you've accrued too much annual leave. That's relevant to all public sector workers and probably in other industries as well and, again, it's not particular to New South Wales. But it has been difficult for people to take leave, obviously, during these circumstances. If you want to give people the opportunity to take leave, you've got to recruit more staff. That's a simple fact. I don't mean to dwell on this, but that furlough number had a very, very significant impact on our system because it then led to people needing to do overtime.

That cumulative effect of not taking as much leave as you would normally and working overtime clearly has had an impact. So it is very important that now, as that furlough number comes down, people are given the opportunity to take leave. We have seen some reduction in emergency department attendances over probably this last three to four weeks. So we're starting to see a little bit of a softening there, which is good to see, and that's important. And you can see a correlation in the fact that performance then tends to rebound somewhat as a consequence of that.

The Hon. EMMA HURST: It almost sounds like there's a reliance on two things: that that trend of presentation at emergency departments will continue to go down and that recruitment will continue to go up. But, as we've heard, there are so many things and outside factors that we cannot control, particularly with how many people are presenting in emergency departments. If that trend doesn't happen, are there any concrete plans to reduce the overtime or to allow staff to take that leave, or is it reliant entirely on (a) that recruitment and (b) a hope that there will be fewer emergency presentations?

SUSAN PEARCE: I certainly wouldn't reduce it to two factors at all. The reduction in—6,000 people at one time, even in a system of our size, is a lot of people. And sick leave, of course, was impacted because it wasn't just COVID related. We had a pretty significant flu season this year as well. So that will assist. None of this is straightforward or simple or on its own. There is a whole lot of other stuff that we could talk about. Again, it's in our submission with regard to the work that we're doing to ensure that people who come to our emergency department are in the right place. We have said many times publicly and in these forums that the people who are the most unwell—our job is to treat them as quickly as we can. Sometimes that means that people who are less

unwell or in lower triage categories wait longer. That is the nature of emergency. And it's the nature of how our emergency departments will always operate.

I think that there is a stack work going on to reduce emergency department reliance and demand. Again, we can point to examples within the ambulance service with our virtual care centre that we established, fortunately prior, in particular, to the Omicron wave. We've done a lot of work over the years, not just during the COVID pandemic, to make sure that we identify people with chronic disease so that we can give them the best care. We've got virtual hospitals. The RPA virtual that we established—again, fortunately, just prior to the pandemic—has been one example of a way that we can treat people safely and carefully in a different way. It also gives our staff an opportunity to do something different, and I think that's an important thing for us to think about as well.

I've been in the health system, like many of my colleagues, for a long time. What is clear to me in this environment is that if we keep trying to replicate things that we've historically done, it just will not work. We have got to try new ways of doing things and new models. We're very focused on that. The younger generation is demanding different things of their workplaces. That is clear. And I think it's more starkly clear now than it has ever been. Younger people are not going to work and do—they've got a much better focus on work-life balance, and I say good for them. But we've got to move with the times and start to think about how we adjust our thinking in that way as well.

The Hon. EMMA HURST: Just moving on, because I've only got a couple of minutes left, one of the key areas of concern that came up in this inquiry was around patients seeking help that have mental health issues that end up in an emergency department and then them having to deal with long waiting times. It's a very difficult environment obviously in an emergency department. And it was suggested that we need more alternative out-of-hours care specifically around mental health. Is NSW Health doing any work in this space, like investments in programs or trials that will help alleviate that issue?

SUSAN PEARCE: Yes. I couldn't agree more about alternatives to emergency departments for people with mental health issues. Really, they are not great environments for mental health. But, of course, there are circumstances where for people, absolutely that is the right place for them to be. There is quite a significant amount of investment in alternatives. One of those is—and I don't mean to continue to reflect back on estimates but it was pretty recent—the Safe Haven models. We have 15 of those. There's been an investment of around $90 million in those. There's a further $5 million to come. We're seeing some positive results from those as an alternative to emergency departments.

We did establish some years ago now the PACER model, which you may have also heard about, between ambulance, police and our mental health services. We've continued to expand those models. Going back to the last report that I can put my hands on in terms of how we compare to other States on this measure, the New South Wales emergency departments have the highest proportion of mental health patients seen on time within triage categories compared to other States. It is something that we've also worked with our clinicians on. We've got some fantastic models in our emergency departments.

The Hon. EMMA HURST: I'll just throw this out quickly because it was one issue that came up, and a brief answer would be appreciated. One young person came in and said that they weren't even aware of what any of these services were. Is there any money going into advertising for those services so that when people need to find them, they can?

SUSAN PEARCE: I think we can always do more on that. It's very important for us to make sure that all of our services are—that people know where they are. Certainly over the last couple of years in particular, we've improved how we communicate, even by social media. So, yes. But I'm happy to take that on notice and think about what more we can do.

Ms CATE FAEHRMANN: Ms Pearce, in March budget estimates I think you were sitting beside the Minister when he was asked by me about ambulance ramping at Westmead Hospital, and he said at that time 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. Did you advise him after that budget estimates hearing that in fact what he said was grossly incorrect?

SUSAN PEARCE: No, I don't recall having that conversation.

Ms CATE FAEHRMANN: When you were sitting next to the Minister and he said to me in response to a question about ambulance ramping and how it was taking place at so many hospitals right across New South Wales, particularly in this situation in south-west Sydney, he said to me that the concept is actually very rare now in New South Wales, you didn't say to him afterwards, "Minister, it's not very rare in New South Wales. What you said in that budget estimates was actually incorrect."?

SUSAN PEARCE: What we have always said—always—is that our system is not perfect and we have some very difficult days. We are clear publicly about that and we're clear with the Minister about that. My recollection of the comment was in the context, as you've said, of other States.

Ms CATE FAEHRMANN: No, I didn't say that. I'm sorry if I—

SUSAN PEARCE: I'm talking about my recollection. I thought you said that he said about other States, didn't you?

Ms CATE FAEHRMANN: No. What he has said on the record and on *Hansard* was, "The concept of what still causes major grief in other States—that is, ambulance ramping—is actually very rare now in New South Wales." Basically, ambulance ramping is very rare in New South Wales. Is that correct, firstly, for March 2022? Was that correct? Was ambulance ramping very rare in New South Wales in March 2022 or now?

SUSAN PEARCE: The Minister's comments are on the record, as you've said.

Ms CATE FAEHRMANN: What it goes down to as well, though, Ms Pearce, is what the department and you are advising the Minister as to what is actually going on in our hospitals, in our health system? If he is coming to budget estimates and seeming to be implying that everything is fine when we are hearing witness after witness during this inquiry basically telling us how much of a crisis our hospitals are in, the question has to be asked: Is the Minister getting the right information or is he deliberately misleading both this Committee and the public about just how bad things are?

SUSAN PEARCE: Our information around our performance has been publicly reported in this State for more than a decade. Our advice to government is always straightforward because we publicly report our information.

Ms CATE FAEHRMANN: When we have witnesses just two days ago who are doctors—who are senior specialists and emergency specialists—working in western Sydney hospitals say that this is basically Third World, what's your response to that?

SUSAN PEARCE: I think we've touched on this already. What I say to that is, that it's not for me to come here and contradict the staff of the health system. They've explained that's their experience. I don't agree with it. NSW Health is not a Third World health system. It resembles nothing like a Third World health system, and I stand by that. Our relative performance around the delay of ambulance patients being transferred to our emergency departments is challenged at times. Do we have the same challenges as other States and the depth of the challenge of other States? No, we do not. Our submission provides publicly available information that goes to that very point. The last data that was provided, and it's in our submission—

Ms CATE FAEHRMANN: That's okay. If it's in your submission I'll leave it there because I've got limited time.

SUSAN PEARCE: Well, I'd like an opportunity to, I guess, essentially reject the comment that you have levelled at me that I'm providing inaccurate information to government.

Ms CATE FAEHRMANN: No. The question was did you correct the Minister when he said it was very rare? I was just asking that.

SUSAN PEARCE: I have provided an answer to that in the sense that we provide publicly available data on our performance.

Ms CATE FAEHRMANN: I want to again go back to previous evidence by senior health specialists working in our public hospital system, particularly in south-west Sydney. One gave the extraordinary example—and he said it's a common example—that the College for Emergency Medicine frequently asks about situations where there's a surge or there's a disaster that needs to be dealt with. Basically, the question is answered on the basis of a hospital having a normal 80 per cent or 85 per cent capacity. But what he has said is that they don't know how to answer the question and they don't know how to approach the question—these are young doctors now working in the system—because every situation is always a disaster. He said 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. It just seems that there's this disconnect between what NSW Health is telling us, what the Minister keeps telling us and what every single witness to this inquiry is telling us, particularly those who are working on the front line in our hospitals. It's a disaster every single day doesn't correlate with what you've just told this inquiry, that we've got the best health system, potentially, in the world.

The Hon. SCOTT FARLOW: Which is what another witness said today as well.

Ms CATE FAEHRMANN: What is going on here?

SUSAN PEARCE: The first thing to say is that I don't believe there's a disconnect between NSW Health and the system. I've been very open and direct about the fact that our staff have been under enormous challenge. I've said that today. I've said it publicly—

Ms CATE FAEHRMANN: They keep saying that the public health system is broken. That's pretty much what most witnesses say straight up.

SUSAN PEARCE: I don't agree that that's what all the witnesses to this inquiry have said because I've heard some of the testimony that's been given. I've also heard a number of them say that the efforts and engagement with NSW Health is strong. We are not disconnected from our system. We know that there are days which are incredibly difficult. I do not support the comment, from my perspective looking at the system, that every day is a disaster.

Ms CATE FAEHRMANN: You have put in submissions, as I understand it, to the Government—it was revealed in a recent edition of *The Saturday Paper* by journalist Rick Morton that NSW Health has put in applications for funding that have been rejected by the New South Wales Government. I understand it was requesting a net cost of service increase of $510 million. In that you said:

> It is critical that the annualisation impact of these new facilities are recognised to meet the ongoing service delivery and operational demands from the community.

In other words, NSW Health is asking the Government for more money. The Government is building all these new hospitals. Internally, within NSW Health, you're lobbying them for more money to meet operational requirements, aren't you, and they're not giving it to you?

SUSAN PEARCE: The first thing I would say is that I think from memory—I'm sorry, I don't have that article but I'm aware of it. I can't remember what year it was from.

Ms CATE FAEHRMANN: Basically, this article, which was a GIPA document, said:

> … increase in activity cannot be accommodated with the existing funding envelope.

They're opening all these hospitals, but there's clearly not enough money within NSW Health, is there, to accommodate the demand?

SUSAN PEARCE: We had a 10 per cent increase in our budget this year. That is a very sizeable increase, given the fact that we've already talked about the quantum of the NSW Health budget. It has gone up substantially over the years. In fact, if you look back, and I've got the figures, we've had an increase of around $8 billion in the last 10 years. Don't forget the money that we've had to manage the COVID pandemic.

Ms CATE FAEHRMANN: Can I check with the increase in funding?

SUSAN PEARCE: Yes.

Ms CATE FAEHRMANN: Again, a lot of witnesses, particularly the doctors, the nurses, the unions and the Australasian College for Emergency Medicine, were telling us that we really need beds. It's access block and there aren't enough beds. I've got data here that suggests that Westmead Hospital in 1997 had 900 beds and it's got 553 now. That's extraordinary. The population in 1997 was just over six million; now it's just over eight million. We're reducing all of these beds around New South Wales. That's a broken system, isn't it? There just aren't enough beds.

SUSAN PEARCE: It is not a broken system. We've just talked about the capital program, which has been significant across this State.

Ms CATE FAEHRMANN: But why is there such a reduction in beds? It's a legitimate question. Why are we reducing beds over decades?

The Hon. SCOTT FARLOW: Well let her answer and she'll tell you.

Ms CATE FAEHRMANN: I'm not sure she was going to.

SUSAN PEARCE: I don't have the bed numbers for Westmead that you've pointed out for that period. What I can tell you is that, for example, the 2011-12 budget for western Sydney was $1.3 billion; it's now $2.1 billion for this year. Models of care have changed substantially over time. People's length of stay in a hospital has reduced. We've changed the way we operate compared to what it was like when I was nursing some years ago, and that's how health systems of the future will need to continue to look. But there is this proposition that increasing beds will cure this issue.

Ms CATE FAEHRMANN: Ms Pearce, I think the question is more like has decreasing beds led to the crisis facing our hospitals now? Again, you're talking about different models of care. Sure, we hopefully do better as we progress through the years. But what we heard on Wednesday, from nurses and doctors, is that it is a horror show of people waiting in corridors. Elderly women who couldn't be examined—in corridors—with dignity, people who were dying. This is what we heard. I'm asking you why do we have such a reduction in beds? Everybody has said how many beds we have had in the seventies and the eighties and the nineties. We were also talking about solutions. When Greg Donnelly asked you about solutions, you didn't mention additional beds?

SUSAN PEARCE: No.

Ms CATE FAEHRMANN: So that's not on the Government's radar?

SUSAN PEARCE: Can I just answer the question?

Ms CATE FAEHRMANN: About the beds?

SUSAN PEARCE: Yes. I can't agree to what you're saying in terms of the numbers because I don't have them in front of me. But if what you're saying is correct, the performance of the health system, as I've said earlier, in the 2000s, even in early 2010, 2011, 2012, was not as good as it is now, and it certainly wasn't—so in 2015 when we made the changes that we made, it wasn't just about ambulance transfer of care. Our surgery performance is excellent. So the performance of the hospital system is better than those years that you refer to.

Ms CATE FAEHRMANN: So with all of the evidence that we heard on Wednesday, again—

SUSAN PEARCE: You also have evidence on the transcript from us that is not being referred to. We've clearly pointed to the performance of the New South Wales health system.

Ms CATE FAEHRMANN: Yes, and I am giving you evidence from people who are working on the front lines, who are telling us that every single day they arrive at 8.00 a.m. and there is 20 people waiting. One of the doctors said that it's a common, everyday occurrence for 30 to 40 people to be in the emergency department when he arrives at work, with 10 to 15 people waiting for beds.

SUSAN PEARCE: We have talked about some of the factors that impact our hospitals. The hospital system doesn't exist, in and of itself, on its own. It is impacted by so many other factors. We've talked a little bit about the aged care and the NDIS, and the number of patients that we have. We've talked about COVID. Even though we're below 1,000 COVID patients, we didn't have that phenomena in our hospitals before. We haven't talked about primary care and the challenges between the primary care system and the hospital system that desperately need to be discussed. So none of these things—

Ms CATE FAEHRMANN: I've got five seconds left and I'm just going to try to squeeze one more question in.

SUSAN PEARCE: Well, I'm sorry, but I haven't been able to answer a question. I haven't been able to give you an answer.

Ms CATE FAEHRMANN: I just feel like the answers are "situation normal". The answers are a little bit like, "Everything is fine."

SUSAN PEARCE: That's not what I'm saying.

Ms CATE FAEHRMANN: We also heard that what NSW Health is doing right now isn't enough, that it is bandaids, if you like, on a system that is collapsing—senior nurses and senior physicians are retiring and moving interstate—and it sounds like the Government isn't really acknowledging how bad it is. Therefore, the solutions can't come if the acknowledgement isn't there of how much of a crisis we're in.

SUSAN PEARCE: Ms Faehrmann, the first thing I will say to is I am not the Government. I am a health professional working in the NSW Health system. I absolutely acknowledge the pressure the system is under. I've said that repeatedly this afternoon. I am not disconnected from the New South Wales health system. I've worked in it almost my entire working life. We have got incredible staff, who have worked under the most difficult of circumstances. We are doing everything conceivable to improve our workplaces for them and that includes working with the Commonwealth, with primary care, to think about how we can find better places for patients to get care that don't need to come to an emergency department, to manage the surgery backlog that we've got as a consequence of the pandemic and get those people the surgery they need as quickly as we can. None of these things sit in splendid isolation. They are all connected to each other and they're only possible because of the staff of the New South Wales health system. I cannot state that strongly enough.

The CHAIR: I think that brings us to the end of—

The Hon. SCOTT FARLOW: It brings us to the Government.

The CHAIR: Yes, to Government members, if they have any questions that they would like to ask.

The Hon. SCOTT FARLOW: Thank you very much, Ms Pearce, for being here today. I think you touched upon it—and we've heard it in the inquiry as well—that, effectively, when it comes to these issues, they're not isolated issues that are just affecting New South Wales. We've seen the front page of *The Australian* today which has the headline about the system failures South Australia is seeing with the new Labor Government in South Australia, and the four worst months recorded when it comes to their wait times. Can you tell us, is there anything we can learn from the approaches being taken in other States? Is there anything we're doing differently in New South Wales or that we could adopt, potentially, from other States?

SUSAN PEARCE: As I said earlier, we're very pleased to assist other States, actually. We've had our colleagues from South Australia come to visit us here in New South Wales, also from WA and from Tasmania. We've offered to assist our colleagues in South Australia by sending some of our team down to have a look and see what we can do to assist them. I think, like us, their staff have experienced a really challenging time. I guess what the experience there tells you is that there is no simple quick fix to these issues. If there was, we would have done that by now because we are all invested in improving the experience of our staff and our patients. So we're always looking to learn from other States because that's how the health system operates—we learn from other countries, we learn from other States.

But, most commonly, they're coming to us, and that's because our data does speak for itself. Despite the challenges that we have—and I don't underestimate those, and I don't diminish them—our performance is strong, and I think it will continue to get stronger as we climb out of this pandemic. I think it's very challenging for us that after what the health system has experienced during the COVID-19 pandemic that that is quickly forgotten. But the impact of it is not forgotten and it's going to take us some time to get through that, and that's what we're aiming to do.

The Hon. SCOTT FARLOW: Ms Pearce, turning to some of that impact from COVID, we've had some discussion today about elective surgery. Of course, we know that while urgent elective surgery—critical elective surgery—continued, non-urgent elective surgery was paused for some period. Can you perhaps outline some of the measures that NSW Health has undertaken to get on top of that elective surgery waiting list?

SUSAN PEARCE: Yes. I might ask Mr Daly to comment, if that's okay?

The Hon. SCOTT FARLOW: Sure.

SUSAN PEARCE: I think I've had my share of talking today.

The Hon. SCOTT FARLOW: You can have a glass of water now.

MATTHEW DALY: I guess what we have experienced, courtesy of a once-in-100-year pandemic, is an elective surgery waiting list above our normal expectation that's at the highest that it has been. But having worked in health for 30 years and this system for most of that 30 years, cyclically, this actually happens. I have cut my teeth on reducing elective surgery waiting lists and, having observed the system after the first wave of COVID, where waiting lists above benchmark levels to be treated rose in excess of 10,000, I also saw that that was when elective surgery was suspended, as it was earlier this year. But then we also saw the system actually recover that 80 per cent in 12 months. Just on that recent experience we've got a challenge now, and that's publicly available information. There are about 18,000-odd cases that are overdue. We have seen that come down each of the last three months to between 200 and 500 cases.

That's not the level we are at because now we are instigating a whole host of formal programs. The LHDs are working very hard. It's very clear from government to the LHDs and to the ministry that this is the priority. Now that we are coming out of COVID we are re-establishing capacity, we are increasing surgical capacity within our public hospitals and we are networking surgical capacity between hospitals to make use of vacant theatre sessions models of care. I mean, day-only hip and knee replacements were unheard of back in the 2000s and nineties. It partly contributes to why we don't need as many beds. But that's a multifaceted question.

We also have engagement with the private sector to the tune that I've not seen in my 30 years in public health services in two States of this country, where we are using and partnering with the private health sector for surge capacity where hospitals within our system can't surge because of furlough and the like. Now, for elective surgery, formal contracts take on large volumes of this. Having observed this system and worked in it for so long, I'm really confident about us addressing that overdue surgery number that is in front of us now. I think we'll see a dramatic improvement by the end of this financial year.

The Hon. SCOTT FARLOW: Is that being backed up by resources, Mr Daly?

MATTHEW DALY: Yes, the Government has provided funding. It's not on my fingertip but there is—

SUSAN PEARCE: It's $408 million this financial year.

MATTHEW DALY: It's $408 million. As the deputy, I should know that.

The Hon. SCOTT FARLOW: So the resources are there to be able to address this backlog but as well you are doing things differently to make sure it's a shorter turnaround time?

MATTHEW DALY: Yes. Like most things in health and elective surgery, there is no one simple solution; it's a whole series and myriad of steps and strategies all executed to complement each other.

The Hon. SCOTT FARLOW: I'm only sitting on the inquiry today but while I think we've heard a lot of different evidence today, it seems to be that everybody agrees at least on one thing. There is no silver bullet when it comes to addressing these issues; it's a multifactorial issue to address. One continuing theme has been about system flow and effectively the challenges with system flow from a whole range of different perspectives, whether it be from the evidence we heard from the pharmacists today or whether it be from surgeons. There are a whole lot of different groups that have a different perspective on their part of the system. I am interested in what NSW Health is doing to work with all of the different participants in the system and what are some of the views you have about how to address system flow.

SUSAN PEARCE: I think it's really important that we hear all those perspectives because it goes to the health of our health system that staff do have the opportunity to raise new ideas and new concepts. I actually saw the comments from the pharmacists and I thought, "Yes, absolutely. That's something we need to look at in our hospitals." I think that's a really important area to focus on. Sometimes there are some little things that you can do that actually make a lot of difference, and they may not seem obvious. That's important. It's why we've always—well, not always, but for the last several years we have dealt with our hospitals as a whole of hospital rather than just focusing on one area. It's important. All of those factors that sit around the hospital system are important to think of as well.

There are many ways that we engage and I think we can actually do more of that. During the pandemic, one of our colleagues Dr Nigel Lyons had established a clinical council and so we were hearing straight from our clinicians every week or every fortnight, depending on what was happening, about issues and what they were experiencing. We've got an Agency for Clinical Innovation that's got thousands of clinicians engaged to provide their ideas and new innovative ways of doing things. I think we can elevate that more in our system. It is really important that people like us, who work in departments and the like, hear directly from clinicians. But, of course, at a local health district level, our chief executives have lots of engagement forums as well. The industrial bodies and the professional colleges—everybody's voice is important in this discussion, and we need that collaboration as we work together to put the pandemic hopefully behind us and think about what the health system of the future looks like.

The Hon. SCOTT FARLOW: Dr Liz Swinburn this morning provided some insight into the role of virtual care and care in the community as well. I am interested in what NSW Health is doing in this space to alleviate some of the issues that we're seeing.

SUSAN PEARCE: I touched on earlier the issue of RPA virtual. We've had lots of visits from other States to come and have a look at that. It's one example and there are many others. I might get Dr Morgan to make a comment about the ambulance VCCC because I think that's been a great addition to the service.

DOMINIC MORGAN: I think this whole topic and the understanding of the problem of flow is critical to understanding the impacts of access block and the fact that flow is easily interrupted at any point along that journey. One of the major things that NSW Ambulance can do, obviously, is try to have an impact on the number of people going in and presenting to an emergency department in the first place. Sometimes that is about identifying early what the appropriate alternative disposition for those patients actually is. If you think about it, people ring 000 and the first thing that is going to be done is it's triaged as an emergency. Virtual clinical care for us provides an opportunity for a structured call-taking approach to divert some of these calls to another clinician who can take a bit more time to properly analyse whether or not some patients might be better off going into another pathway.

I will give you a really good example around residential aged-care facilities. Very commonly an ambulance would be called via 000 to attend a residential aged-care facility. Now we actually refer a call that is not identified as immediately life-threatening to a clinician in our Virtual Clinical Care Centre. According to a secondary triage, where they ask more questions, we've been able to successfully divert more than 2,000 calls since we've had our virtual clinical care set up, with an 85 per cent referral rate. The patients are either looked after by their own GP, looked after by the local health district team or the aged-care assessment team or looked

after by the actual aged-care facility themselves. An 85 per cent diversion back to care that is appropriate for their condition, rather than to an emergency department, is a really good way of actually reducing care.

In the 12 months that we've had just the VCCC working, we've managed to deal with more than 13,591 patients who we have been able to divert off to other dispositions. Likewise, we engage with Healthdirect in a similar sort of pathway. In the last 12 months we've diverted 67,000 patients to those, of which they have been able to deal with the patient's presenting condition in a way other than sending them to an emergency department in more than 52 per cent of cases. So you can see 10,000 here, 10,000 there and 100,000 here. Eventually, it helps to reduce the load of us presenting to any given emergency department, of which we would be—depending on the LHD—22 per cent to 30 per cent of any load. It's a significant strategy to ensure people actually get to the right place for the right condition that they have.

The Hon. AILEEN MacDONALD: I just have one question. You did an ED patient survey in 2021. Is there one available for 2022? I only say that because you said they rated their care as very good, which was unchanged from the year before. Also, of the percentage of people who present, what percentage actually completed the survey?

SUSAN PEARCE: I would have to take that on notice. I don't have that information, I'm sorry.

The Hon. LOU AMATO: Ms Pearce, you mentioned earlier about possibly looking into what pharmacists can do. Is that something that NSW Health is going to look into?

SUSAN PEARCE: Yes. I think there's an opportunity there to think about how we can better equip ourselves in that regard in our hospitals, specifically. One of the common issues that creates delays in people being discharged from hospital is waiting for discharge medications. That's just a very simplistic example, but it can be quite impactful. I think there's an opportunity for us to think about that. As I say, we leave no stone unturned. We certainly make every effort to take on board those suggestions, so I am happy to look at it.

The Hon. LOU AMATO: Thank you very much.

The CHAIR: Whilst we probably could go on further, I think we've had a fair go. On that point about the pharmacists, I will make this observation. I thought the evidence from the pharmacists this morning was very interesting. I don't make this statement as a criticism, but other witnesses—and the ones, in particular, before lunch—have spoken of the need to laterally understand this system-wide situation we are in. I take your comment that, in terms of the pharmacists' evidence, it may not be a matter that had been on your radar but you've heard it for the first time. I am not criticising you, but one wonders how many other stones are out there that could do with a bit of a flip. More to the point, how do we get those stones flipped to get them onto the table and discussed so that the full universe can be looked at, as far as we practically can, as opposed to dealing with these matters in almost discrete silo discussions? There is a sense of that.

SUSAN PEARCE: Are you asking me a question, Mr Donnelly? Or are you making—

The CHAIR: I guess I'm giving you a lecture, which I've got no right to do.

SUSAN PEARCE: What I would like to reinforce with you, though, is the response I gave previously, and that was that we do have an Agency for Clinical Innovation. I think it's important not to leave you with the impression that we deal with this on a piecemeal basis. We actually have for many years taken a whole-of-hospital approach to this.

The CHAIR: Yes, you made that point.

SUSAN PEARCE: And the ACI has been instrumental in that. What I'm saying is that there are always new ideas and we should be open to considering those. But thank you for the lecture.

The CHAIR: At that point we will wind up. Thank you all very much. I appreciate you coming in. We are very grateful, obviously. The comments do not go in any way, shape or form to the individuals. They are all working very, very hard dealing with enormous challenges. Our thanks obviously go to those individuals who have worked exceedingly hard for us.

(The witnesses withdrew.)

The Committee adjourned at 15:12.