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13 October 2023

Fiona Murphy
Secretary
**Select Committee on Transfer of Care Delays (Ambulance Ramping)**
Parliament House
HOBART TAS 7000

Email: transferofcare@parliament.tas.gov.au

Dear Ms Murphy

Thank you for the opportunity to make a submission to the House of Assembly's Select Committee on Transfer of Care Delays (Ambulance Ramping).

I would refer members to the **Australian Medical Association** *Ambulance Ramping Report Card 2022* [1] for an insight into the issue of ramping across the country, which shows that all states have seen a significant decline in reaching their transfer of care targets.

On behalf of our members, doctors from across the primary and acute care sectors, I provide the following comments on the Committee's Terms of Reference.

**(a) the causes of transfer of care delays, acknowledging Federal and State responsibilities.**

Ambulance ramping is unacceptable. The role of Ambulance Officers and Paramedics is to respond to emergencies in the community, not to be an additional healthcare worker minding a patient on an ambulance stretcher in a corridor or in an ambulance due to an inability of an Emergency Department (ED) to admit those patients.

We know other Tasmanians risk having their health impacted if they do not receive timely ambulance care because of ambulances being ramped. Having said that, ramping in our EDs is only the symptom of a far greater problem that extends across the entirety of the healthcare system.

The simple reason ambulances are ramped and unable to transfer care is because there are not enough inpatient hospital beds for the number of patients needing admission. The result is patients being ramped in the ED waiting for an ED bed to be seen and assessed, which are, in turn, blocked by admitted patients waiting for the insufficient number of available inpatient beds.

Inpatient beds are in high demand from the increasing demand on services from an ageing and growing population with increasing chronic diseases. But they also have beds blocked by patients;

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[1] AMA Ambulance Report Card - www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf

specifically, patients waiting for sub-acute care in another environment, whether at home, in aged care or through the NDIS.

There are other reasons too, including access to sufficient staff to open beds on any given day, lack of discharge processes over weekends, underutilisation of transit lounges (this is improving), etc., all of which need to be addressed to help with patient flow into and out of the hospital environment.

To address the more complex reasons for ambulance ramping for the long term requires primary and acute care reform, more general practitioners in the community, better support for GPs servicing rural hospitals, more acute and subacute beds, more aged care and NDIS services with the ability to take sub-acute patients, more built health infrastructure, more investment in digital infrastructure, more Hospital-in-the-Home and GEM@Home beds, more housing, more dental care, more support for Tasmanians to live healthier lives, and, more dollars from both levels of government. To make all of this happen, cooperation and shared vision will be needed across all sectors of government to generate the cultural changes necessary to attain these goals.

Because our hospitals are having to deal with an ageing population in a largely low-socio economic community with increasing complex care needs of patients, without a whole of system approach, you can open more inpatient beds, but they will be quickly filled, and the problem of ramping will return.

**b) the effect transfer of care delays has on: —**

**(i) patient care and outcomes.**

The Medical Journal of Australia published an article by Cate Swannell (4 July 2022) based on Victorian research that showed "Longer ambulance offload times are associated with greater 30-day risks of death and ambulance re-attendance." [2] Patients waiting for longer than 17 minutes saw increased mortality. Ideally, patients should be able to be transferred into the care of the ED within 15 minutes. In reality, this is impossible to achieve for many patients with the current resources across our public hospitals. We are working on protocols to mandate transfer of all patients from ambulance care within 60 minutes, which will be challenging for the current system as it is, if not impossible.

**(ii) ambulance response times and availability.**

When the AMA researched ramping in Australia in 2022[3], Tasmania had a target of 85 per cent of transferring from the ambulance to the emergency department within 15 minutes, and 100 per cent within 30 minutes. Tasmania's patient transfer performance has deteriorated year-on-year since at least 2015-16, where 92.1 per cent of patients were transferred within 15 minutes, and 95.2 per cent were transferred within 30 minutes.

In 2020-21, 65.9 per cent of patients were transferred within 15 minutes, and 79.6 per cent within 30 minutes. This compares with the previous year, where 80.4 per cent of patients were transferred within 15 minutes, and 85.7 per cent of patients within 30 minutes. This represents a 14.5 per cent deterioration and 6.1 per cent deterioration in performance for the 15- and 30-minute targets, respectively, compared to 2020-21. The situation has only worsened in the 2021-22 year with 57.4 per cent of patients offloaded within 15 minutes at the Royal Hobart Hospital (RHH) and 58.8 per

[2] https://www.mja.com.au/journal/2022/ambulance-ramping-associated-30-day-risk-death#:~:text=%E2%80%9COur%20major%20findings%20are%20that,associated%20with%20presentations%20by%20people

[3] AMA Ambulance report card

cent at the Launceston General Hospital (LGH). At the RHH 65.7 per cent were offloaded within 30 minutes and 64.6 per cent at the LGH.[4]

Naturally, the more ambulances are ramped, the less available they are to other patients in need.

The median emergency response times have been worsening statewide, rising from 12.9 minutes in 2018-19 to 14.1 minutes in 2021-22. While there have been slight improvements in Burnie and Devonport, the figures for Hobart and even more so for Launceston reflect the worsening trend.[5]

**(iii) wellbeing of healthcare staff.**

Stress and burnout are increasing for those working on the frontline. The result is doctors, nurses and paramedics leaving their frontline positions for other work within healthcare or leaving the profession entirely.

Not being able to provide the care you are trained and expect to be able to give to patients is leading to increased "moral injury" being experienced by healthcare professionals.

Moral injury refers to the psychological, social, and spiritual impact of events on a person who holds strong values (such as caring for patients) and operates in high-stakes situations (hospital emergency care) but has to act inconsistent with those values.[6]

Symptoms of moral injury can include strong feelings of guilt and shame as well as high levels of anger and contempt towards the system that prevents proper care.[7] For those staff working in ambulances or on the floor of EDs unable to move admitted patients onto wards, the risk of moral injury is high.

Similarly, those working on wards can suffer moral injury when they are aware that a patient no longer needs acute care but cannot leave for lack of appropriate support and that they are blocking a much-needed bed for another patient.

**(iv) emergency department and other hospital functions.**

As a rule, a well-resourced hospital should have at most 85 per cent of beds occupied at any one time. This allows for the ebb and flow of emergency department patient flows to be accommodated with timely admissions on to the wards for those patients requiring ongoing acute care.

Neither the RHH nor the LGH have been able to operate at this level for some time, resulting in the backlog of patients waiting in the ED for admission, and the ramping of ambulances.

The inability to have patients admitted to the acute health system when needed increases the divide between general practitioners and the hospital system, creating an 'us and them' scenario which benefits no one.

**(c) the adequacy of the State Government's data collection and reporting for transfer of care delays.**

Efficient and effective data collection is vital for future planning, especially for budget provision, but it is essential for the collection of data not to impede the caregiving or place additional burdens on already overburdened staff. Additional staff and resources will be needed to ensure efficient and effective data collection.

[4] Department of Health Annual Report 2021-22 p66

[5] DOH Annual Report 2021-22 p69

[6] AMA Victoria, *Moral injury: What happens when exhausted health workers can no longer provide the care they want for their patients* – Dougal Sutherland

[7] Ibid

We aren't collecting data on jobs which could be avoided if there was another service to divert the patient to. Especially in rural jobs where an on-call medical service would avoid a drive to DEM. For example, if the state paid for a GP or a HITH service to provide services in rural areas this would reduce some jobs needing to go to DEM and sit on the ramp.

Need to collect data on:

- Avoided paramedic transfers if able to engage with a doctor (e.g., GP)
- GPs engaging in HITH or COMMRS
- Unnecessary RACF transfers to DEM - e.g., fall with head strike when there is a clear CoG Model Palliative care pathway.

**(d) the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures.**

The issues of ramping and pressures being experienced in our EDs is not new. They have been growing for decades as our population has grown older and larger in size. The RHH ED has been expanded over the years to try to solve the problem and is currently going through another expansion redevelopment project.

In 2019, AMA Tasmania was part of the Access Solutions Summit, called to address the growing pressures in the various EDs across the state.

Dr Frank Nicklason said at the time "it is well documented that patients across Tasmania are subjected to ongoing hospital access block, preventing them from receiving timely hospital care in the right location within the prescribed time frames." He went on to add, "lengthy delays both in overcrowded emergency departments and on elective waiting lists have serious consequences, including avoidable patient harm, and anguish for clinical staff unable to deliver timely care in the location they know would be best for their patients."[8]

Following on from that summit, there has been work progressed on measures to try to improve patient flow through the hospital. Some of these have slowed down with the impact of COVID-19 and more needs to be done.

For example, MedTasker, a clinical task management tool has been introduced across all hospitals to try to improve communications among hospital staff when delegated tasks or managing tasks.

Another digital tool, Making Care Appropriate for Patients (MCAP) helps to determine whether a patient is in the right place to receive the care they need. MCAP supports daily patient flow decisions.

A new Inter-Hospital Transfer policy allowing patients to be admitted directly to another hospital's ward rather than going through the ED again has alleviated some pressure. However, what it needed is more beds, which also means more staff, which we acknowledge is difficult in the current national climate of skill shortages, but the new Salaried Medical Practitioner's Agreement should help to make Tasmania a desired place to work for doctors.

More beds do not necessarily mean in a hospital environment.

We strongly support the Hospital in the Home program (HITH) which is to be expanded from 12 beds supported in the community to 22 beds, including some beds specifically for older persons**. However, the expansion is too slow and should be closer to 100 community beds if it is to make a difference to the bed block issues being experienced at the RHH and LGH.** The COVID@Homeplus program has

[8] AMA Tasmania Media Statement *Emergency Department Access Solutions Meeting* 18 June 2019

shown how for some conditions, care and monitoring of a patient can be effectively provided remotely.

The HITH program can also be provided into nursing homes. Proper care plans for older patients are also an effective way of knowing what a patient wants in terms of care before they get sick. Some patients do not want to be in an acute hospital environment if they have a choice. Indeed, it is safer for them in some circumstances to be treated in their home than risk acquiring hospital-based infections.

However, it is essential that these expansions of services do not come at the expense of the existing community-based services such as COMRRS which also needs to be expanded and rolled out across a larger proportion of the state, especially in outer urban areas of low-socio-economic status.

**(e) measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects.**

Ambulance ramping and bed block are issues affecting EDs and hospitals nationwide. The fact that it is a problem in all states means there are no simple solutions that can be imported that will fix our issues.

There are various levels of investment in IT across the country with electronic patient records and integrated systems that allow for real-time information to be available to specific groups of people including patients.

For example, providing patients with information around how long they can expect to wait in an ED may help that patient decide to see a GP or go to an Urgent Care Centre instead or to be empowered sufficiently to make other decisions around their family and themselves in the knowledge they will be waiting for x number of hours for care.

**(f) further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays; and**

Bring forward infrastructure funding across the health portfolio: frustration is mounting for our members around masterplans with thirty-year timetables as is the case with the Royal Hobart Hospital Masterplan 2020-2050, and in the case of the St John's Park Masterplan, twenty-years.

We want to see the entire RHH Masterplan brought forward, which means the St John's Park redevelopment too. We cannot afford to wait twenty-years to see Stage 3 of the RHH Masterplan, as now seen largely through the St John's Masterplan, finished, noting Stage 3 of the RHH redevelopment plan is now broken down into four stages under the St John's Masterplan.

We have urged the government to immediately start the redevelopment of all stages of the St John's Park plan and commit to a revised timeline so that the entire Masterplan building is completed by no later than 2035.

This is in line with AMA Tasmania's policy position to see all acute hospital infrastructure around the state completed by 2035.

We need improved facilities and more beds urgently; therefore, these concept plans need to be quickly developed into a real commitment to start to build the required infrastructure now.

In mental health, the sooner a proper mental health facility is built at St John's Park that enables all acute services, which is short stay and inpatient, to be removed from the RHH into properly designed premises with recovery design principles at its core, the better. This will also free up badly

needed space for inpatient beds at the RHH. Again, the current 10-to-15-year window for this to occur is far too long.

**(g) any other matter incidental thereto**

The Commonwealth Government cannot be let off the hook. They also need to address the issues that are seeing general practice under enormous pressure to provide affordable health care in an increasingly expensive environment.

Bulk billing is disappearing because GPs cannot afford to bulk bill. As a result of these pressures, general practice is becoming a less attractive pathway for doctors to choose, making it harder for patients to see a GP in a timely manner or to be able to afford healthcare. Evaluate analysis has shown the cost of an ED presentation is 19 times the cost to the taxpayer than a partially funded visit to the GP.

We know delayed care leads to worse outcomes. The commonwealth needs to do more to address these problems with Medicare. Urgent Care Centres only go a small way to assisting EDs deal with bed block (if at all – we wait for data to show us their impact).

The commonwealth also needs to support the provision of appropriate healthcare in the Aged Care Facilities it helps to fund as well as through the NDIS packages it funds, to help people get out of acute care hospital beds into more appropriate sub-acute beds, receiving the ongoing care they need within their home environment.

Finally, there is also the issue of under-investment in preventative health measures, which would help Tasmanians stop or delay the onset of a number of chronic conditions.

**Conclusion**

In conclusion, while there will always be ideas for further improvement that can be identified, the underlying issue of inadequate staffed bed capacity across our health system, and particularly the RHH, must be recognised, quantified, and addressed.

We can not allow inaction to occur.

That means we all need to support reform at the health system level as well as within the wards and EDs to ensure the system is performing at its best in the interests of patient care.

It also means that **new** funding must be provided to fund business cases put forward to address these problems. For instance, it has taken far too long to see the expansion of the HITH program.

Thank you once again for the opportunity to comment on this submission.

Kind regards,

Dr John Saul
President
AMA Tasmania