AMA

Ambulance Ramping Report Card 2026

Contents

President's message

As President of the Australian Medical Association, I am honoured to present this year's Ambulance Ramping Report Card. Ambulance ramping continues to be a critical symptom of the logjam in our public hospitals — a significant and growing challenge directly affecting the safety and wellbeing of patients, paramedics, and the broader health system.

This year's report paints a stark picture: in 2024–25, more patients than ever required ambulance services, with more than 2.4 million people arriving at emergency departments by ambulance, and ambulance callout incidents reaching a record high.

The findings highlight more than half of all ambulance incidents now result in hospital presentations, placing additional pressure on already stretched emergency departments. The system is struggling to keep pace with demand. Despite a minor improvement in performance during 2024–25, we remain concerned by the longer-term decline since the COVID-19 pandemic.

Across every state and territory, ambulances are spending significantly more time ramped outside hospitals compared to five years ago, contributing to delays in patient care and reducing the availability of ambulances to respond to other emergencies.

Ambulance ramping also exacts a heavy toll on doctors working on the frontline. Emergency department clinicians are increasingly forced to deliver care in overcrowded, high-pressure environments that fall well short of what they know patients deserve — often without appropriate space, resources, or staffing. Treating patients in corridors, managing prolonged handovers, and juggling unsafe workloads undermines clinical decision-making, disrupts continuity of care, and places doctors in morally distressing situations where they cannot provide timely, high-quality treatment. Over time, these conditions contribute to profound fatigue, burnout and declining morale, driving experienced clinicians away from emergency medicine and the public system altogether. This loss of skilled staff further exacerbates access block (entering hospitals) and ramping, creating a vicious cycle placing patients and the health workforce at ongoing risk.

The AMA continues to advocate for urgent action to address access block, calling for increased investment in hospital capacity, improved patient flow, and stronger support for our frontline staff. We believe no patient should be left waiting in an ambulance or a hospital corridor because of systemic bottlenecks that compromise care and put lives at risk. It is imperative governments address these issues to reduce ramping, free up beds, and improve patient outcomes across the country.

In addition, we must look at mechanisms to reduce the demand for ambulance and hospital care. In a time of rising chronic disease and multimorbidity, this means strong investments in general practice and preventive medicine to keep people well, manage disease out of hospital, and contain rising demand for acute services.

This report card complements our Public Hospital Report Card 2026 and Public Hospital Report Card — Mental Health edition 2025, each providing vital insights into the mounting pressures faced by Australia's public hospital services. Our report cards document ongoing challenges with rising demand and declining performance in Australian emergency departments, and underscore the urgent need for policy settings that allow for accessible, high-quality healthcare.

Together, these publications reinforce the AMA's commitment to evidence-based advocacy and our determination to ensure every Australian — no matter where they live — can access timely, high-quality care when they need it most. We remain steadfast in our call for meaningful reform and investment to support the staff, patients, and communities who rely on our public health system.

Dr Danielle McMullen

President

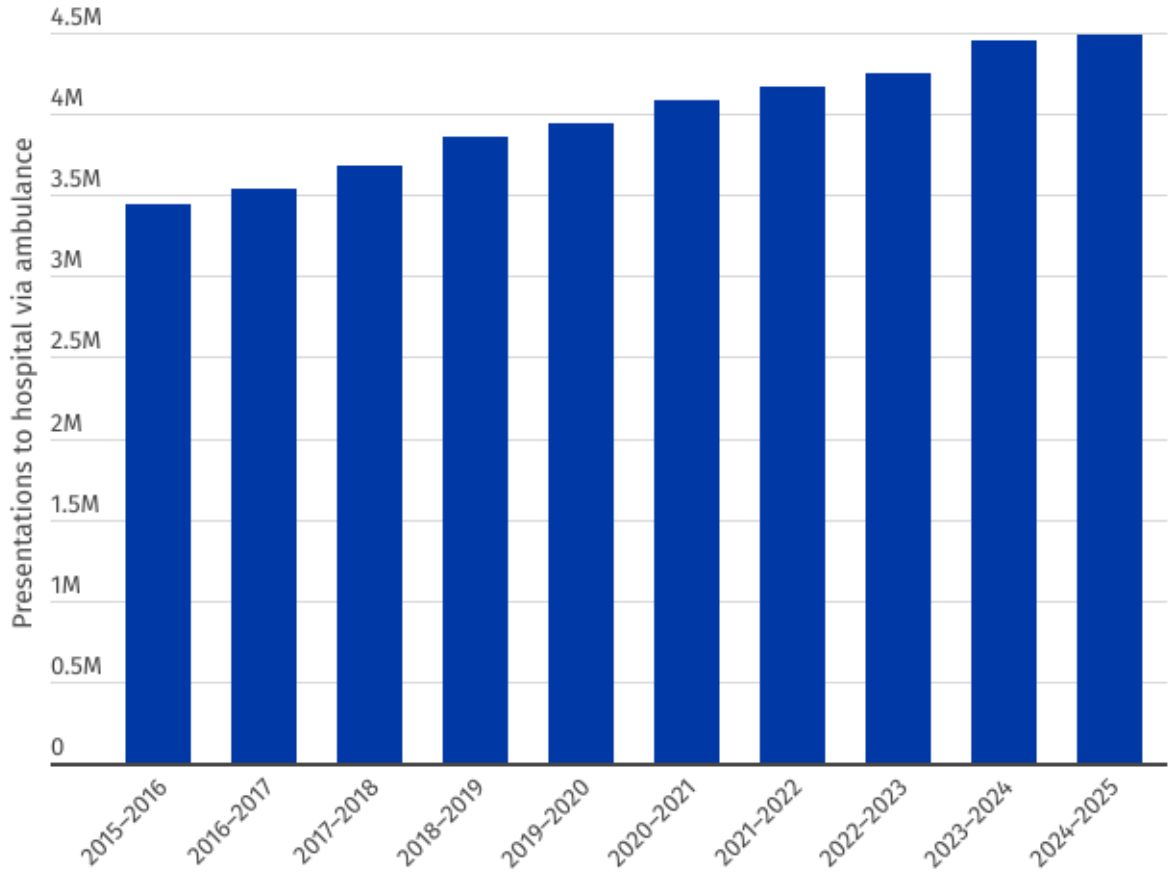
Australian Medical Association

National overview

Ambulance services are essential for the delivery of safe, high-quality, and timely care, providing critical emergency response services to stabilise and transfer patients to the hospital emergency department. In 2024–25, there were 9.1 million presentations to Australian public hospital emergency departments in total, with more than a quarter of patients (2.4 million) arriving at emergency departments via ambulance.[i]

In 2024–25, about 54 per cent[iiiii] of incidents requiring an ambulance resulted in a presentation to the emergency department. As demonstrated by Figure 1, the total number of incidents requiring an ambulance in Australia reached a record high during 2024–25 at nearly 4.5 million. While this trend is likely to continue as Australia's population grows, incidents per capita were also the second highest on record.

Figure 1: Number of incidents requiring an ambulance, 2015–16 to 2024–25[iv]



Source: Productivity Commission.

As previously reported in the AMA's Public Hospital Report Card 2026, Australia's emergency departments have been struggling to keep up with rising demand for many years, despite the best efforts of our world-class medical staff. Performance has declined significantly since the onset of COVID-19, with a much-needed — though modest — uptick in 2024–25.

This Ambulance Ramping Report Card — the second to include five-year longitudinal comparisons across each Australian state and territory where data is available — presents an eerily similar picture. Ambulances are spending more hours ramped outside hospitals than they were just five years ago, highlighting the critical need for increased investment in Australia's public hospital system to clear the logjam, reduce pressure on staff, and improve patient outcomes.

What is ambulance ramping?

The definition for "ambulance ramping" differs between states and territories (see below). Generally, patient off-stretcher time (POST) or transfer of care (TOC) starts when an ambulance arrives at the hospital and ends when care of the patient is transferred to the emergency department and clinical handover has been finalised.

When an emergency department is at capacity, patient transfer is unable to be performed in a timely manner. Australia's emergency departments are operating at capacity, meaning patients must often receive treatment from paramedics in either the ambulance or in the hospital corridor until a free bed becomes available. It also means paramedics are unable to respond to subsequent ambulance callouts while they wait with patients.

This delay is most commonly referred to as either ambulance ramping, ambulance offload delay, ambulance turnaround delay, or patient off–stretcher time delay.

Australia is facing alarming levels of ramping, with reports of individuals being driven to emergency departments due to a lack of available ambulances, and some people dying while waiting for an ambulance. It is essential we invest in the capacity of our emergency departments to reduce ramping, free up beds, reduce strain on staff, and improve patient outcomes.

Data on the care provided in Australian public hospital emergency departments is collected to measure and report on activity and performance. The time taken for patients to be transferred off an ambulance stretcher and into a hospital emergency department is a key indicator of a hospital's capacity to treat patients in a timely manner.

Data methodology

Where data is collected using the same methodology, this report compares results across states and territories, as is the case with Productivity Commission data on the number of incidents requiring an ambulance. However, not all data is comparable. This report card does not track national performance or compare data between jurisdictions relating to ambulance ramping, due to the inconsistency of reporting mechanisms. Each state and territory collects data differently and measures the start and end time of 'ramping' differently. It would therefore be inaccurate to compare performance of one state or territory against another.

There are methodological differences between POST or TOC, including how each is operationalised in practice. For example, some states hand over care to emergency department staff earlier, some may collate multiple patients under the care of a single ambulance, while others wait until patients are transferred into the physical emergency department under the care of emergency department staff. Definitional differences also exist between emergency department treatment zones and emergency department admissions, as well as in arrival times and formal handover processses. Furthermore, jurisdictional differences — including the number of ambulances per capita, policy settings such as patient cost versus free ambulance access, and geographical factors — all influence ambulance utilisation rates in each state and territory and therefore affect ramping. Finally, data collection methods, information technology systems, and the range of hospitals included in reporting can also vary between states and territories.

The AMA has been advocating for more consistent reporting metrics across state and territories, and for an Ambulance Ramping National Minimum Data Set to be developed. Table 1 provides a summary of the performance targets and reported performance for each state and territory.

Ambulance ramping remains a significant and persistent pressure point across Australia's health system, yet its true impact is often not fully reflected in available data. While official metrics provide important system-level insights, they can mask considerable variation in how ramping is experienced on the ground, reflecting differences in local demand, staffing, hospital capacity, and operational practices. Clinicians and paramedics frequently report that the reality of prolonged delays, overcrowded emergency departments, and compromised patient flow can feel far more acute than the aggregated data suggests.

This disconnect is compounded by inconsistencies in how ramping is defined and recorded across jurisdictions, as well as the reliance on state-level reporting that obscures performance at individual hospital sites. As a result, some facilities may experience substantially worse outcomes than indicated by headline figures and data, underscoring the need to complement quantitative data with frontline perspectives to better understand the scale and consequences of ambulance ramping.

Table 1: Ambulance ramping definition for each state and territory

Jurisdiction	Local terminology	Definition
New South Wales[v]	TOC (within 30 minutes)	The time interval commencing at the time an ambulance arrives at hospital to the conclusion of a structured clinical handover and offloading of the patient from the ambulance stretcher and/or when the ambulance paramedics are no longer required.
Victoria[vi]	TOC (within 40 minutes)	The total time in minutes that it takes from when an ambulance arrives at an emergency department to the time when the patient is transferred to the hospital and handover is complete.
Queensland[vii]	POST (within 30 minutes)	This measure reports the percentage of ambulance patients transferred off-stretcher within 30 minutes. Off-stretcher time is defined as the time between when a Queensland Ambulance Service (QAS) ambulance arrives at the hospital with a patient, and when that patient is transferred off the QAS stretcher into the emergency department (ED). The transfer off stretcher is part of the patient handover and indicates the patient has been transferred to the hospital ED for care.
Western Australia[viii]	TOC (within 30 minutes)	The length of time between the arrival of an ambulance at a hospital emergency department and the time the patient is transferred from the care of a St John WA (SJWA) ambulance paramedic crew to the care of the emergency department staff.
South Australia[ix]	TOC (within 30 minutes):	Handover from South Australian Ambulance Service clinician to a hospital clinician for ongoing care, once the South Australian Ambulance Service clinician and equipment is no longer required.
Tasmania[x]	TOC (within 45 minutes)	The time between patients arriving at a hospital and the transfer of care from Ambulance Tasmania staff to Tasmanian Health Service emergency department staff. On 15 December 2025, Tasmania reduced the definition of ambulance ramping from TOC occurring within 60 minutes to within 45 minutes.
Northern Territory[xi]	TOC	Time interval commencing at the arrival of an ambulance at the receiving facility and concluding with transferring the patient off ambulance stretcher and their care to the receiving facility. It encompasses the transition of responsibility for the patient's care.
Australian Capital Territory[xii]	Turnaround time	The time from when the resource arrives at hospital to when it is available to be assigned to another incident.

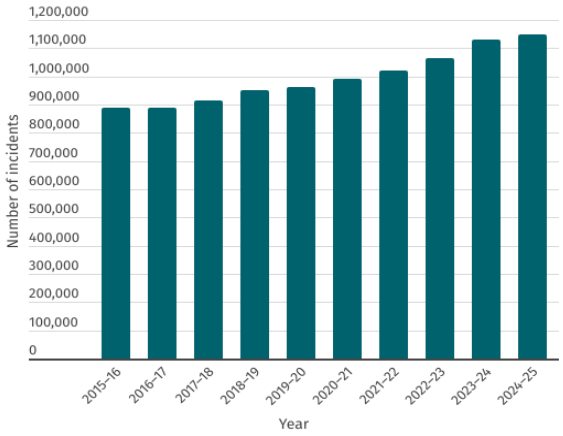
New South Wales

In 2024–25, there were 1.15 million incidents requiring an ambulance in New South Wales (Figure 2), representing a 1.7 per cent increase from the previous year. On a per-person basis, New South Wales had 134.4 incidents per 1,000 people, up from 133.9 in 2023–24.[xiii].

New South Wales has set a target to transfer 90 per cent of cases from ambulance to hospital staff within 30 minutes.[xiv] In 2024–25, more than 80 per cent of patients were transferred within 30 minutes,[xv] which fell below their own target. However, it is a 2 percentage point improvement from the previous year (78 per cent) (Figure 3). Note there is significant seasonal variation in transfer times within 30 minutes, where it is significantly lower in the winter months (June/July), reflecting higher demand in the population in those months. New South Wales has not met the 90 per cent target since 2018–19.[xvi]

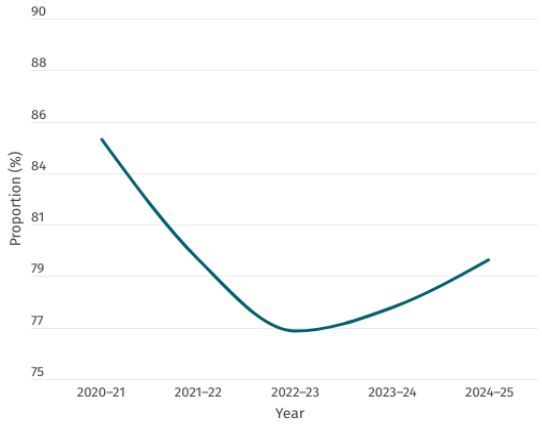
During the January to March 2025 quarter, NSW Ambulance transitioned to a new clinical response grid which streamlined the number of response categories. As the new Category 1 — Life threatening (CAT 1) and the previous Priority 1A — Highest priority (P1A) both refer to ambulance responses within 10 minutes, the Bureau of Health Information (BHI) continues to present historical trends for these responses, which are now referred to as 'life threatening (CAT 1)'. Given the functional continuity of this metric, both metrics are presented together in Figure 4. Please note that other new categories are not comparable with previous 'priorities' and BHI reporting on these responses begins in the April to June 2025 quarter. For more detail on this New South Wales data, please refer to Attachment 1: Data Quality Statement.

Figure 2 (NSW): Number of incidents requiring an ambulance, 2015–16 to 2024–25



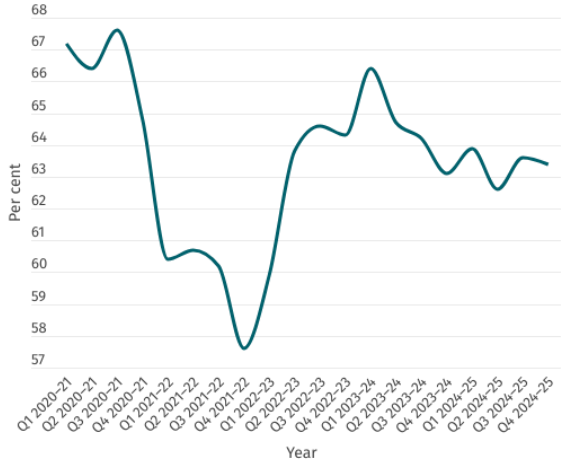
Source: Productivity Commission.

Figure 3 (NSW): Proportion of patients transferred within 30 minutes, 2020–21 to 2024–25 (target: 90 per cent)



Source: NSW Health.

Figure 4 (NSW): Ambulance responses within 10 minutes, Q1 2020–21 to Q2 2024–25



Source: NSW Health.

Victoria

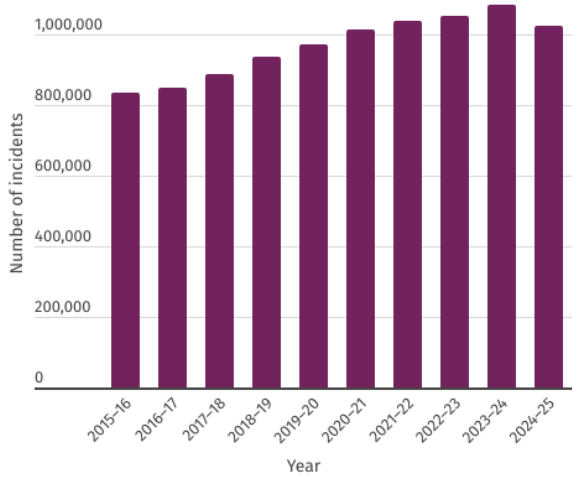
In 2024–25, there were 1.03 million incidents requiring an ambulance in Victoria (Figure 5), representing a 5.4 per cent decrease from the previous year. On a per-person basis, Victoria had 146.5 incidents per 1,000 people, down from 157.2 in 2023–24.[xvii]

Anecdotally, members have reported that Victoria's 2024–25 fall in recorded ambulance incidents may be partially explained by the state's increased active management of lower-acuity cases, which aims to avoid unnecessary emergency ambulance dispatch. Ambulance Victoria reports that Video Assisted Triage (VAT) — expanded across its Secondary Triage operations during the reporting period — was used in 35,092 cases, with 22,122 (63 per cent) of these cases diverted from emergency ambulance resources and referred to alternate services.[xviii]

Victoria has a target of 90 per cent of cases being transferred from the ambulance to the emergency department within 40 minutes.[xix] In 2024–25, 68 per cent of patients were transferred within 40 minutes. [xx] This represents a 3 percentage point improvement in performance from the previous year (65 per cent) (Figure 6).[xxi] However, it remains 4.7 percentage points below the performance five years prior in 2020–21 (72.7 per cent) (Figure 6).[xxii]

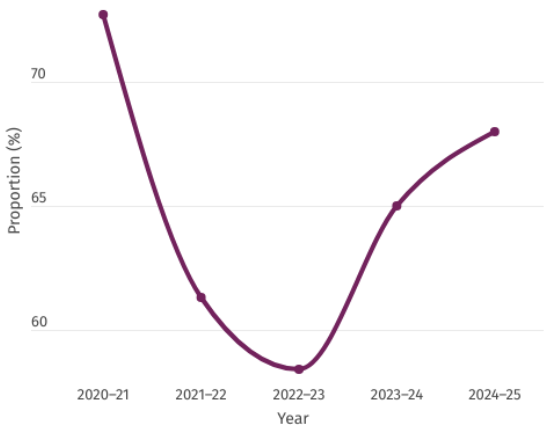
Victoria also monitors the "average ambulance clearing time". While a specific definition is not provided, the metric refers to the time it takes for an ambulance to become available for the next call after delivering a patient to the hospital. The last time Victoria achieved its target of 20 minutes was in 2019–20.[xxiii] The clearing time has grown significantly since then, rising to 31.4 minutes, according to Victoria's 2024–25 annual report (Figure 7).[xxiv]

Figure 5 (Vic): Number of incidents requiring an ambulance, 2015–16 to 2024–25



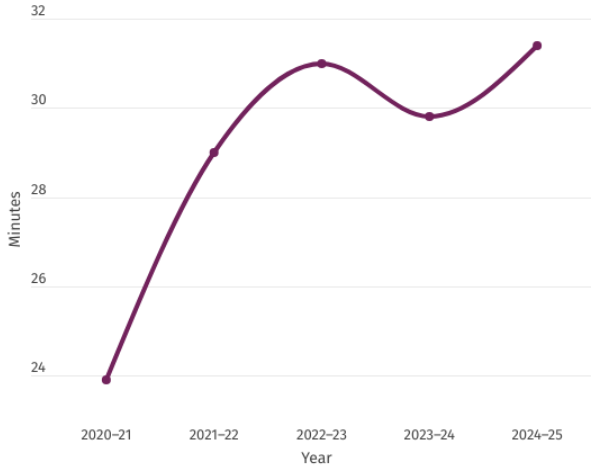
Source: Productivity Commission.

Figure 6 (Vic): Proportion of patients transferred within 40 minutes, 2020–21 to 2024–25 (target: 90 per cent)



Source: Ambulance Victoria.

Figure 7 (Vic): Average ambulance clearing time in minutes, 2020–21 to 2024–25 (target: 20 minutes)



Source: Ambulance Victoria.

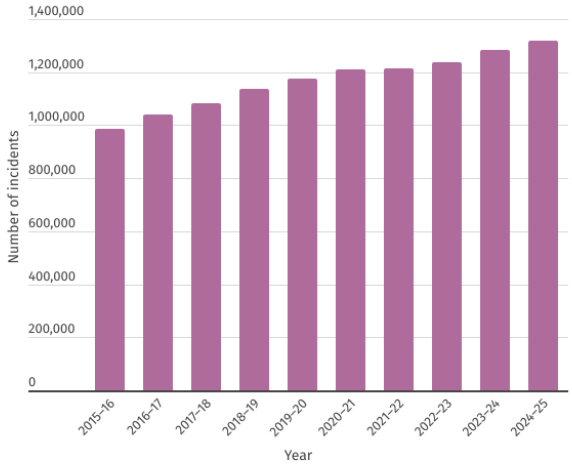
Queensland

In 2024–25, there were 1.32 million incidents requiring an ambulance in Queensland (Figure 8), representing a 2.6 per cent increase from the previous year. On a per-person basis, Queensland had 234.6 incidents per 1,000 people, up from 232.4 in 2023–24.[xxv] This is the second highest in the country, and a figure that may be driven, in part, by the state's policy of free ambulance transfers.

Queensland has a target of 90 per cent of cases transferred from the ambulance to the emergency department within 30 minutes. This target has not been met in 10 years.[xxvi] In 2024–25, 59 per cent of patients were transferred within 30 minutes in Queensland's top 26 hospitals.[xxvii] This represents a 3.4 percentage point improvement in performance from the previous year,[xxviii] but a 6.2 percentage point deterioration from 2020–21 (65.2 per cent) (Figure 9).[xxix]

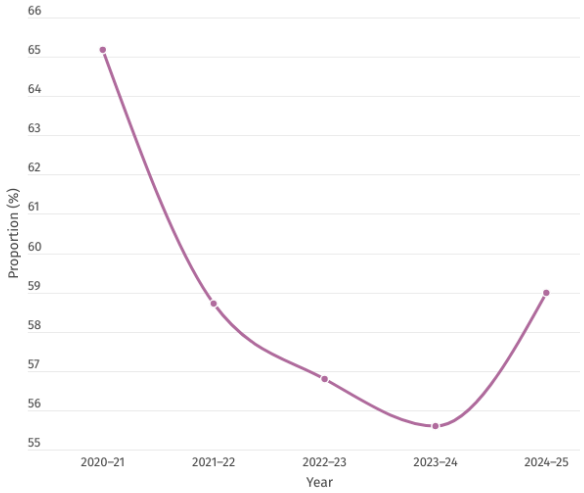
In 2024–25, ambulances spent about 116,000 hours ramped outside Queensland hospitals,[xxx] a significant and welcome decrease from the previous year's total hours ramped of roughly 157,000 hours (Figure 10).

Figure 8 (Qld): Number of incidents requiring an ambulance, 2015–16 to 2024–25



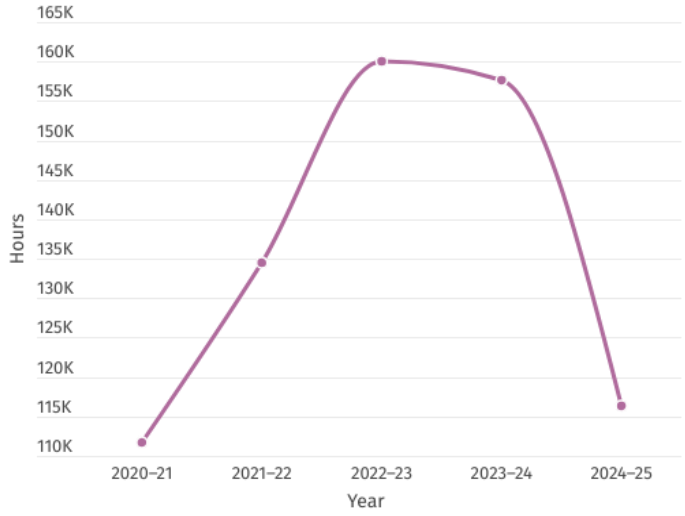
Source: Productivity Commission.

Figure 9 (Qld): Proportion of patients transferred within 30 minutes, 2020–21 to 2024–25 (target: 90 per cent)



Source: Queensland Audit Office.

Figure 10 (Qld): Total hours of ambulances ramped, 2020–21 to 2024–25



Source: Queensland Health.

Western Australia

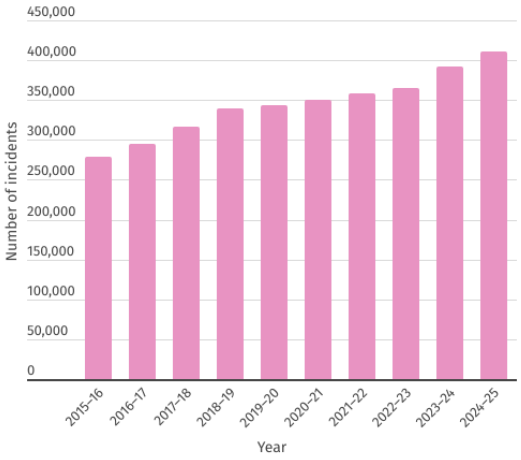
In 2024–25, there were more than 410,000 incidents requiring an ambulance in Western Australia (Figure 11), representing a 4.7 per cent increase in incidents from the previous financial year. On a per-person basis, Western Australia had 136.6 incidents per 1,000 people, up from 134.0 per 1,000 people in 2023–24.[xxxi]

Western Australia has set a target of all (100 per cent) cases being transferred from the ambulance to the emergency department within 30 minutes.[xxxii] In the 2024–25 financial year, 65 per cent of patients were transferred from an ambulance to the emergency department within 30 minutes, a 3 percentage point decrease from the previous year (Figure 12).[xxxiii]

According to WA Health data, the number of ramped hours increased dramatically in 2024–25 to about 63,000 ramped hours, compared to about 48,000 in 2023–24 (Figure 13).[xxxiv] September 2025 was the worst month on record at a total of 7,268 hours ramped.[xxxv] On this measure, St John WA has a dashboard,[xxxvi] which is available for public use.

The AMA notes a variation between the total hours ramped reported in Figure 13 and the total hours ramped reported on the St John WA Dashboard. While these figures often vary slightly, this year the variation in the Extended Transfer of Care data was significant. According to the St John website, the total for the 2024–25 financial year was 65,054 hours, whereas the data provided by the Department of Health totalled 63,333.5 hours — a difference of 1,721 hours. WA Health advises that "differences in results occur in public reporting between SJAWA and DOH, which can be attributed to variations in the scope of activity being reported on." For more detail on this variation, please see Appendix A: Data Quality Statement.

Figure 11 (WA): Number of incidents requiring an ambulance, 2015–16 to 2024–25

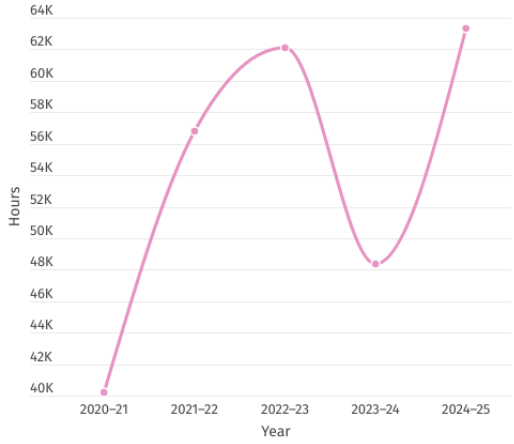


Source: Productivity Commission.

Figure 12 (WA): Proportion of patients transferred within 30 minutes, 2020–21 to 2024–25 (target: 100 per cent)

Source: WA Government.

Figure 13 (WA): Total hours of ambulances ramped, 2020–21 to 2024–25



Source: WA Government.

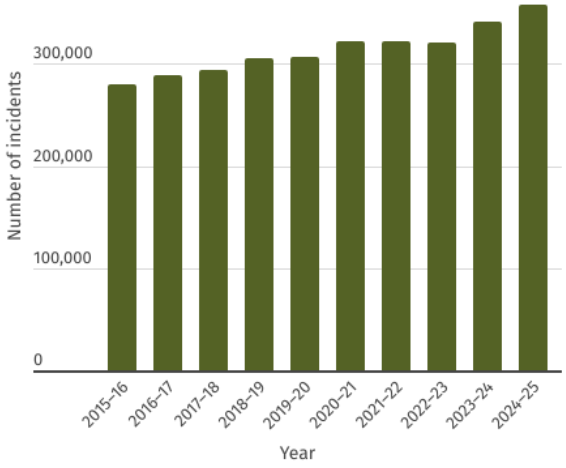
South Australia

In 2024–25, there were nearly 360,000 incidents requiring an ambulance in South Australia (Figure 14), representing a 4.9 per cent increase in incidents from the previous financial year. On a per-person basis, South Australia had 189.1 incidents per 1,000 people (Figure 14), up from 182.7 per 1,000 people in 2023–24.[xxxvii]

South Australia has set itself a target of 90 per cent of cases being transferred from the South Australian Ambulance Service paramedics to hospital clinical staff within 30 minutes.[xxxviii] In the 2024–25 financial year, 45.7 per cent of patients were transferred within 30 minutes (Figure 15), representing a 1.6 per cent decline on the previous year (Table 15).[xxxix] South Australia's performance in this metric has fallen 18.1 percentage points over the past five years, from 63.8 per cent in 2019–20 to 45.7 per cent in 2024–25.[xl]

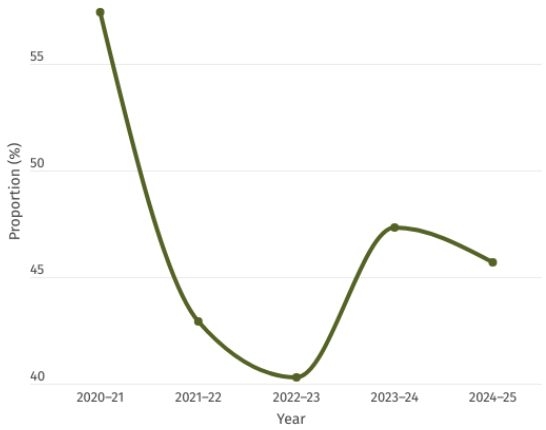
The total hours ramped outside of South Australian hospitals has more than tripled since 2019–20, rising from more than 15,000 hours in 2019–20 to more than 49,000 hours in 2024–25.[xli] July 2025, which is outside of the reporting range captured in Figure 16, recorded the highest monthly figure on record at 5,866 hours.[xlii]

Figure 14 (SA): Number of incidents requiring an ambulance, 2015–16 to 2024–25



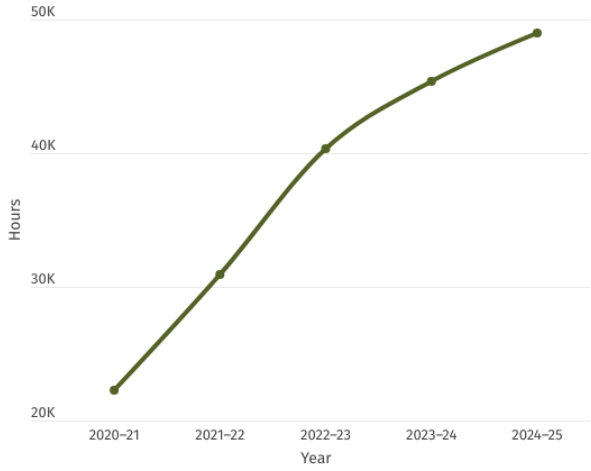
Source: Productivity Commission.

Figure 15 (SA): Proportion of patients transferred within 30 minutes, 2020–21 to 2024–25 (target: 90 per cent)



Source: SA Health.

Figure 16 (SA): Total hours of ambulances ramped, 2020–21 to 2024–25



Source: SA Health.

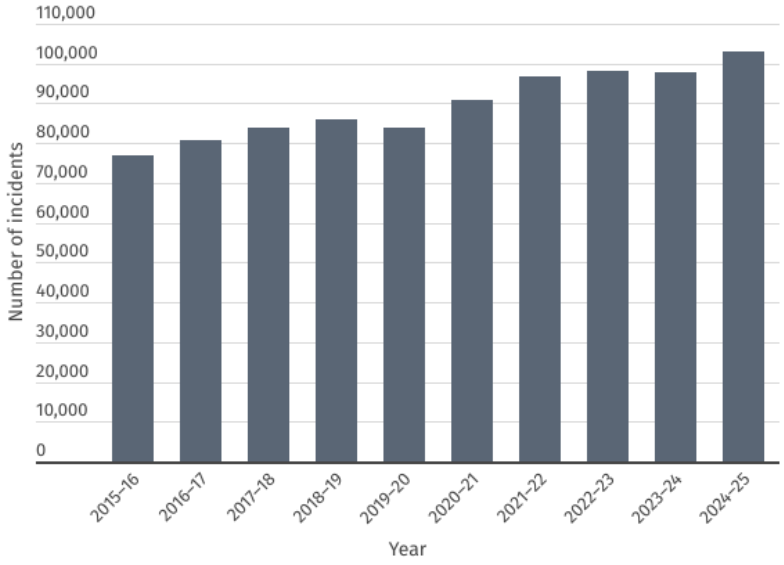
Tasmania

In 2024–25, there were more than 100,000 incidents requiring an ambulance in Tasmania (Figure 17), representing a 5.3 per cent increase in incidents from the previous financial year. On a per-person basis, Tasmania had 178.8 incidents per 1,000 people, up from 170.1 per 1,000 in 2023–24.[xliii]

Tasmania has recently changed the way its ambulance ramping figures are reported. Prior to 2023–24, the state reported on hospital-by-hospital percentage of patients transferred within 15 minutes and 30 minutes. In April 2024, a new "transfer of care" policy was implemented in Tasmania's public hospitals.[xliv] This policy made it official protocol that the transfer of patients from ambulance to hospital staff should occur within 60 minutes, allowing paramedics to get back on the road. Given this change of performance metrics, the AMA is unable to provide longitudinal reports on long-term trend data, therefore no five-year comparison is included below.

As of 19 December 2024, the target for Ambulance Tasmania incidents that achieve transfer of care to hospital staff within 60 minutes is 100 per cent.[xlv] However, the target was 85 per cent at the start of 2024–25 and raised multiple times throughout the year. Therefore, the average target across the whole financial year was 95.4 per cent, yet the actual proportion of patients transferred within 60 minutes was 85.7 per cent in 2024–25 (Figure 18).[xlvi]

Figure 17 (Tas): Number of incidents requiring an ambulance, 2015–16 to 2024–25



Source: Productivity Commission.

Figure 18 (Tas): Proportion of patients transferred from ambulance within 60 minutes, 2024–25 (average target: 95.4 per cent)

Source: Tasmanian Department of Health.

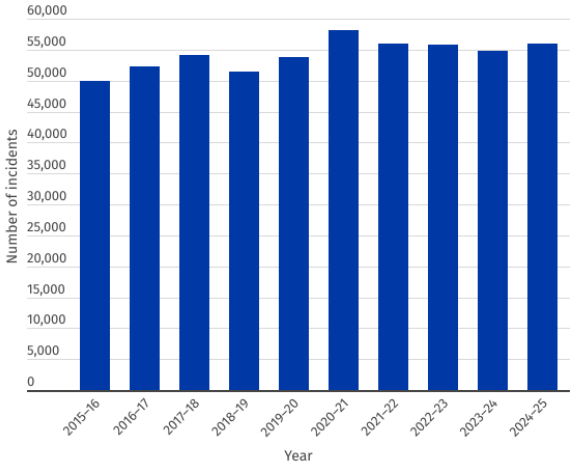
Australian Capital Territory

In 2024–25, there were more than 55,000 incidents requiring an ambulance in the Australian Capital Territory (Figure 19), a 2.1 per cent increase on the previous year. On a per-person basis, the Australian Capital Territory had 116.2 incidents per 1,000 people (Figure 17), down from 116.6 in 2023–24.[xlvii] This remains the lowest per-person usage of ambulance services in Australia.

The ACT reports on "turnaround time", which is the time from an ambulance arriving at the hospital to when it is available to be assigned to a new incident. This time includes the transfer of care of the patent, as well as time spent completing paperwork, restocking the ambulance, debriefing, and other tasks required between incidents.

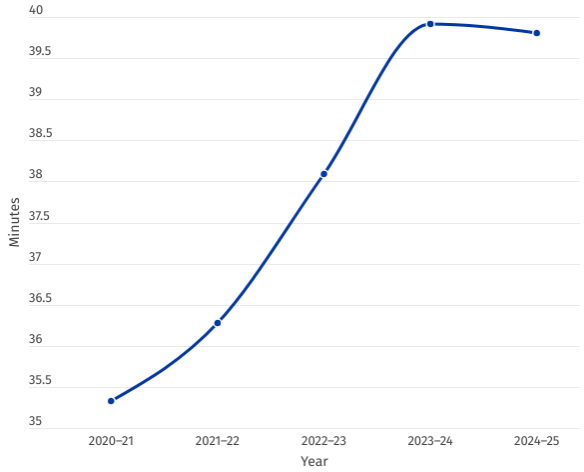
In 2024–25, the median turnaround time for ACT ambulances was 39.8 minutes, which is functionally identical to the 2023–24 figure of 39.9 minutes.[xlviii] However, this measure of ambulance ramping has grown by 12.7 per cent over the past four years, up from 35.3 minutes in 2020–21 (Figure 20). At the 90th percentile (meaning the slowest 10 per cent of cases), it took 64.8 minutes for ambulance turnaround in 2024–25, up from 58.9 minutes in 2020–21 (Figure 21).

Figure 19 (ACT): Number of incidents requiring an ambulance, 2015–16 to 2024–25



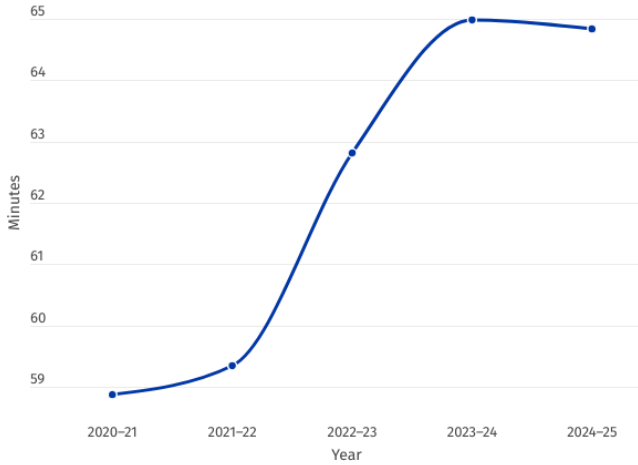
Source: Productivity Commission.

Figure 20 (ACT): Ambulance Turnaround Time, 50th Percentile, 2020–21 to 2024–25



Source: ACT Government.

Figure 21 ACT): Ambulance Turnaround Time, 90th Percentile, 2020–21 to 2024–25



Source: ACT Government.

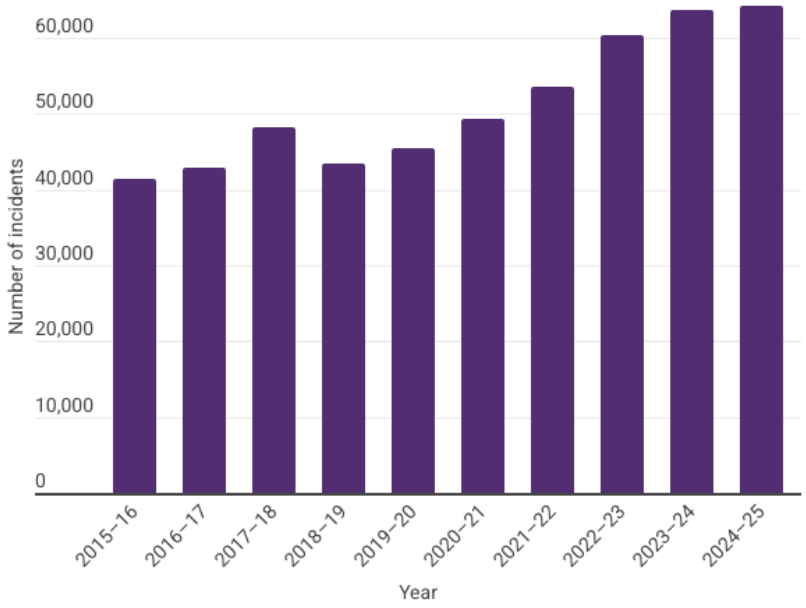
Northern Territory

In 2024–25, there were more than 64,000 incidents requiring an ambulance in the Northern Territory (Figure 22), representing a 0.7 per cent increase from the previous financial year. [xlix] The Northern Territory had 244.8 incidents requiring an ambulance per 1,000 people, down from 251.2 per 1,000 people in 2023–24. Despite the fall, this remains the highest figure in the country.

The territory has set itself a performance indicator of all (100 per cent) ambulances being "turned around" in 30 minutes.[l] In 2024–25, 68.3 per cent of patients were transferred within 30 minutes, representing a four percentage point drop compared to 2023–24. In 2024–25, ambulances spent 9,773 hours ramped outside of Northern Territory hospitals, an increase of more than 1,100 hours since 2023–24.[li]

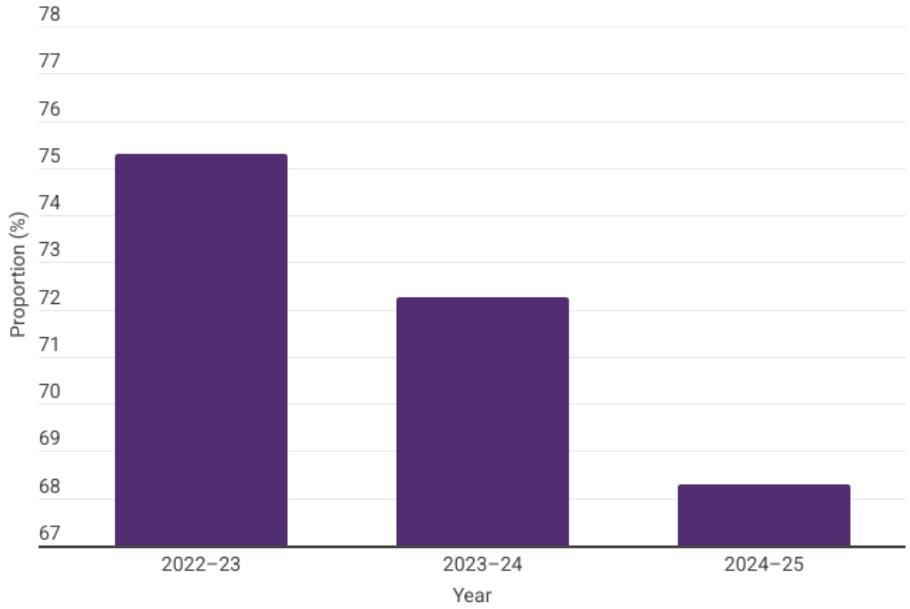
St John NT did not track transfer of care time prior to November 2022, when this field became mandatory within the electronic patient care record (ePCR) system. Previous metrics were based on the KPI of turnaround time, meaning five-year longitudinal comparisons cannot be made for the NT.

Figure 22 (NT): Number of incidents requiring an ambulance, 2015–16 to 2024–25



Source: Productivity Commission.

Figure 23 (NT): Proportion of patients off stretcher in under 30 minutes (target: 100 per cent), 2022–23 to 2024–25



Source: St John Ambulance Service (Northern Territory).

Appendix A: Data Quality Statement

Overall

Due to inconsistencies in reporting methods across each state and territory, this report card contains a compilation of data retrieved from a range of sources, including from annual reports, online dashboards, and information provided directly by states and territories.

References are made only to metrics directly referred to within the text, with data from previous years (used to build longitudinal graphs) having been archived by the AMA or available in past editions of annual reports.

For information on metrics relating to previous years, please contact the AMA directly.

New South Wales

During the January to March 2025 quarter, NSW Ambulance transitioned to a new clinical response grid, which streamlined the number of response categories.

The previous emergency response categories were replaced by the following:

- Category 1 — Life threatening
- Category 2 — Emergency
- Category 3 — Urgent
- Category 4 — Less urgent.

As the new Category 1 — Life threatening (CAT 1) and previous Priority 1A — Highest priority (P1A) are reasonably similar, the Bureau of Health Information (BHI) is continuing to present historical trends for these responses, which are now referred to as 'life threatening (CAT 1)'. Other new categories are not comparable with previous 'priorities' and BHI reporting on these responses begins in the April to June 2025 quarter.

The trended measures for Life threatening (CAT 1) are presented alongside new categories Emergency (CAT 2) and Urgent (CAT 3) in Figure 4 in the BHI Healthcare Quarterly report.

All historical results are available in the BHI Data Portal.

Queensland

Ramping is the complement of POST (1 – POST). It is calculated from the Patient Off Stretcher Time (POST) data. While POST represents the proportion of patients who are 'off-stretcher' (that is, transferred from the ambulance stretcher to hospital care) within 30 minutes, ramping indicates the proportion not transferred within 30 minutes.

Reporting is consistent and limited to Queensland Ambulance Service (QAS) Code 1 and 2 incidents that result in transport to an emergency department, have a valid at-hospital time interval (>0 and <480 minutes), are recorded with a completed status, and occur at Queensland's top 26 facilities.

POST is publicly reported on the Queensland Health Our Performance website.

The total number of hours that ambulances spend ramped at Queensland public hospital emergency departments is not publicly reported. Queensland Health publicly reports the average lost minutes per ambulance and the number of patients transferred off stretcher within 30 minutes data via the Queensland Health Our Performance website. Results for in-month and quarterly performance are reported for the "Top 26 facilities" as well as statewide. Lost minutes (and hours) are not an accurate measure of system performance and can be misinterpreted. Total lost minutes are influenced not only by emergency department flow but also by the number of ambulances, overall demand for services, population size, and geographic dispersion.

In some situations, additional time is required to safely transfer a patient from a QAS ambulance into the care of hospital emergency department clinical staff. Without considering growth in factors such as the number of Code 1 and Code 2 arrivals, ambulance fleet size, and overall service demand, total lost minutes does not provide an accurate metric of operational efficiency, nor does it allow comparison across jurisdictions or with past performance. Queensland Health encourages moving toward a rate (i.e., average lost minutes per ambulance) as a more appropriate reporting metric for these comparative purposes.

Western Australia

St John Ambulance WA (SJAWA) is continually striving to improve the quality of its data. The WA Department of Health receives daily updates to the data collection from SJAWA, and the data may change as quality improves.

Some differences in results occur in public reporting between SJAWA and the department, which can be attributed to variations in the scope of activity being reported on. The daily cases extract the department receives from SJAWA includes the following:

- Priority 1, 2, or 3 and Original Priority 1, 2, or 3 cases (emergency transports) attended statewide
- Priority 4 and Original Priority 4 cases (booked transfers) attended in country WA
- Priority 4 and Original Priority 4 cases (booked transfers) with high patient transfer acuity attended in metropolitan Perth.

The boundary between metropolitan Perth and country WA is as defined in the Emergency Ambulance Services Agreement.

SJAWA figures may also include cases that fall outside the department's extract scope. Lastly, there may be other reasons for differences as well, but as the department has never been given full access to all the SJWA data, it is limited in what can be investigated.

Tasmania

The target for Ambulance Tasmania incidents that achieve transfer of care to hospital staff within 60 minutes, as specified in the February 2025 update of the Service Plan is 100 per cent. This was the correct target at that point in time, but it was not the target for the entire financial year. The target was 85 per cent at the start of 2024–25, then increased to 90 per cent on 21 August 2024, then to 95 per cent on 20 October 2024, before reaching 100 per cent on 19 December 2024. The average target across the whole financial year was 95.4 per cent.

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