Submission to the House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping).

I am a Palliative Care Medical Specialist with over 40 years' experience in hospitals and the community. I have worked throughout Australia and New Zealand. I was a Senior Lecturer at the Australian Institute of Health Innovation at UNSW.

Palliative Care is one of the few services that sees patients in all settings, including Residential Aged Care and interacts with GPs, hospital specialists, community nursing and all allied health specialties. Consequently, palliative care staff gain insights into the health system as a whole.

I acknowledge the positive contributions of many submissions and the bravery of patients and family members in telling their tragic stories of the impact of delays on their care.

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

The overall causes of ramping are too many people presenting to hospital because alternative ways of caring are not available to them, that ramping itself leads to worse outcomes for patients meaning that their hospital stay is longer, making bed block and ramping worse, internal processes in hospitals that are inefficient, and delayed discharges.

The RACGP submission made some valid points, particularly the need to improve the management of chronic conditions so that patients do not deteriorate to the point that they need to go to hospital. However, many Tasmanians are unable to see their GPs as often as they should, or at all, because of cost, lack of timely appointments and because many practices are not taking on new patients.

Aged care homes (RACFs) are a particular problem. The submission of the Australian Nursing & Midwifery Federation (Tasmanian Branch), highlights many of the issues with RACFs. As well, RACFs do not appear to have any obligation to ensure a timely medical assessment in the facility whenever one of their residents becomes acutely unwell. When the resident's allocated general practitioner, assuming there is one, is unavailable there is no back up. The default is to send the resident to the Emergency Department, even if it is contrary to the patient's Advanced Care Plan, their wishes or the wishes of their families. In any case, RACFs remain inadequately staffed to cater to the increased needs of their residents, when they become more unwell. Only registered nurses can administer controlled drugs and new medications, to treat acute illnesses. Where electronic prescribing is used in the RACF, locum GPs, geriatricians and palliative medicine specialists who visit, are unable to prescribe new medications because they cannot sign into the system. This means that the patient is either sent to hospital immediately or they get worse because they do not receive the medications they need and then go into hospital.

The economics of general practice defeats GPs who wish to provide a service to RACFs. For example, seeing a patient in a RACF might take a GP 60 minutes, including travel time, which is not reimbursed. If the GP works in a practice that does not routinely bulk-bill, which is now most of them, the GP would typically earn $70 (Medicare rebate plus patient co-payment) for each 15 minute consultation ($280/hour). The RACF visit would be additional to the GP's full working day, as many practices have all available appointments filled. GPs already spend unfunded time doing paperwork at the end of the day, so a RACF visit adds to a GP's working day, for inadequate remuneration (approximately $80). Increased reimbursement by itself will not improve the situation. While it might lead to GPs spending more time in RACFs routinely, there is no guarantee that they will be available at short notice.

The RACP submission identifies difficulties discharging patients and the interface with community and GP services. My experience in many hospitals is that there is a lack of urgency in discharging patients. They are waiting for scans that could be done after they leave hospital, or they are kept under observation or to fine tune their treatment, when they are well enough to go home. The

discharge destination and how discharge can be achieved should be considered on the first day of admission to hospital and be front of mind throughout the hospital stay. When medical follow up is required, GPs should receive an incentive to review patients at the appropriate time, as determined by the hospital team.

(b) the effect transfer of care delays has on:—
(i) patient care and outcomes;
(ii) ambulance response times and availability;
(iii) wellbeing of healthcare staff;
(iv) Emergency department and other hospital functions;
These matters have been covered in detail by other submissions. There is no doubt that ambulance ramping results in inadequate care and poor outcomes for patients and unacceptable stress on staff.
(c) the adequacy of the State Government's data collection and reporting for transfer of care delays;
The state government should seek data from RACFs on their arrangements for timely medical assessment, their care plans for patients who become confused, the take up of Advanced Care Directives, Goals of Care documentation and Medical Guardianship and how often these are followed when determining place of care.
The most important data is evidence of improvement as care redesign is rolled out.
(d) the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures;
(e) measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;

No evidence of this in the previous report – except to reference academic institutions and the Oak Group data tool.
https://doh.health.tas.gov.au/__data/assets/pdf_file/0004/416821/Newnham_and_Hillis_Review_-_2019.pdf

The health system in Christchurch, New Zealand, had the same difficulties a decade ago as Tasmania has today. The Kings Fund Report https://www.cdhb.health.nz/wp-content/uploads/c476aa13-canterbury-kings-fund-report.pdf describes how system change improved patient care, saved money, reduced waiting times and ended ramping. I have recently spoken to a senior doctor in Christchurch who confirmed that ramping is still not a significant problem.

(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

1. The guiding principle of reform should be the "right care, in the right place, at the right time, by the right person" (Kings Fund Report). Care should always accord with the wishes of the patient and the family.
2. The Tasmanian government must step up and take responsibility for system change based on best practice. While all the submissions from professionals and professional bodies have highlighted the deficiencies in the system and have provided many useful ideas, there is a tendency to focus on their own problems and propose solutions that benefit themselves, sometimes at the expense of other professionals. Most of the submissions advocate for an increase in the state health budget. Not only is more money hard to come by, if it were just a question of money, the other states with greater health spending per person wouldn't have the same problems with ramping as we have in Tasmania. The Tasmanian government needs to facilitate a co-operative approach between health professionals and organisations. No doubt there will be pushback and bureaucratic delays.
3. RACFs are a Commonwealth responsibility but this doesn't mean that the Tasmanian government is powerless to act. It should co-operate with RACFs to improve care and gain

the support from the Commonwealth to achieve this. If RACFs are performing poorly, are stone-walling reform and there is data to back this up, the state government should name and shame them. The state should improve access to HiTH for aged care, as recommended by the submission of Dr Tolman and colleagues. However, outreach services need to be supported by appropriately-skilled doctors, visiting the patient in the RACF, if the patient's GP is not available. It would be cost-effective even if the doctor was paid by the Tasmanian government. Patient care assistants, who could assist with returning the patient to bed, should be part of the HiTH team. Similarly, it would be cost-neutral if sitters for confused patients were sent to the RACF from the hospital pool, as they would be required anyway if the patient was transferred to hospital. The Tasmanian government should attempt to recover some of these costs from the RACF, which would improve the health budget.

4. Develop Health Pathways (Kings Fund Report) for the management of common conditions. The plans should enable the ambulance triage of categories of patients to an Urgent Care Facility (UCF) rather than a hospital emergency department. The UCF would provide comprehensive treatment so that the patients could then return home. Only if the triage proved to be inaccurate would they need to go to hospital. All staff in the UCF should be trained to a high standard so they could confidently manage the range of conditions they would be expected to see.

   Patients repeatedly admitted to hospital with shortness of breath from cardiac failure or chronic respiratory illness are disparagingly called "frequent flyers". They are often referred to palliative care with the noble aim of keeping them out of hospital. Such referrals are usually inappropriate because these patients are often not dying, don't accept that they are dying and expect to have emergency treatment to make them well again. Many would benefit from cardiac or respiratory rehabilitation. In my experience it is extremely rare that these patients have a Health Pathway, incorporating a plan for the management of shortness of breath at home, including follow up to ensure that they understand the plan and are confident to carry it out. I was once referred a patient who had been admitted with breathlessness six times in the previous twelve months for up to 4 weeks at a time and was requesting euthanasia (before it was legalised) because he was sick of being sick. He also never wanted to come to hospital again. Our team commenced the plan described above. The patient avoided hospital for the next 18 months, with much improved quality of life, before he died peacefully. Implementing these plans could prevent hundreds of admissions per year.

(g) any other related matters incidental thereto.

The Newnham and Hills Review in (e) claims that the Tasmanian eHealth strategy will alleviate the problem of ramping by improving the co-ordination of care. However, the eHealth strategy is several years away from implementation and, surprising as it may seem, electronic medical record (EMR) systems have serious deficiencies that reduce health worker productivity, not just during the long learning curve but indefinitely.

https://www.sciencedirect.com/science/article/abs/pii/S0735675713004051

For example, it takes an experienced hospital doctor five times longer to prescribe a single medication through a typical EMR compared to a paper chart. If nurses and doctors are already battling to complete their work every day, which they are, and a bad EMR will reduce their efficiency, then the problems of ramping and bed block will get worse.

I can discuss the pitfalls of EMR-implementation in much more detail, based on research I have been undertaking in the last two years, if requested.

Kind regards

Dr Frank Formby