29 July 2024

Dr Rosalie Woodruff
Committee Chair
Select Committee on Transfer of Care Delays (Ambulance Ramping)
Parliament House
HOBART TAS 7000

Dear Rosalie

Thank you for the opportunity to add to AMA Tasmania's submission of 13 October 2023 to the previous Select Committee's inquiry into Transfer of Care Delays (Ambulance Ramping).

Since that submission the new Transfer of Care Protocol (TOCP) has come into effect with a staged progression towards a goal of having all ambulances off the ramp within 30 minutes or less. While the AMA supports an end to ambulance ramping, we are opposed to the mandatory nature of the TOCP. With appropriate investment in the right services, access block and thereby ramping would not be an issue.

The reality is Tasmania's health and aged care system is under resourced for an ageing population with increasingly complex chronic comorbidities, sometimes requiring long term care placement on discharge. This under resourcing has led to the growing problem of ambulances being ramped, which is due to Emergency Departments (EDs) being access blocked to the inpatient hospital beds. Patients are suffering due to long waits for care in ED waiting rooms, and there is clear evidence that access block in ED's is associated with increase mortality in patients requiring hospital care. While patients in ED's are suffering, so too are the patients who experience postponements and delays for their urgent and elective surgery. The result is a mounting sense of moral injury, within the workplace among healthcare workers, as healthcare is simply unable to be delivered in the right space for the right patient in the right time.

Transfer of Care Protocol

Nobody wants to see ambulances delayed in attending emergency situations in the community because paramedic staff have been unable to hand over medical care of a patient to ED staff. However, the failure by government to consult properly on the TOCP led the Tasmanian Industrial Commission (TIC) to order further consultation to take place with the AMA and the Australian Nursing and Midwifery Federation (ANMF). While small progress towards a more workable solution was made, it was insufficient to satisfy AMA Tasmania. It remains the position of AMA Tasmania that the consultation process was inadequate as it was limited to the wording of the protocol, and not whether it should be mandated, nor what actions would be required to address the impact of the mandatory transfer of care on ED staff and other parts of the hospital. The fact is, as the mandated TOCP had already been agreed to by government, it was not true consultation and there was no ability to change/ influence the outcome of that fundamental aspect of the protocol. The revised TOCP remains a mandatory transfer of care protocol in all but name.

The AMA and ANMF have repeatedly highlighted the health system issues that have created the ramping problem, as noted in our previous submission. In summary, the problem lies in an under resourced health system that is struggling to cope due a health system that has not be resourced for the current, and the predictable clinical need demand.

The specific issues are:

1. Inadequate numbers of inpatient beds at the acute hospitals: the bed deficiencies are site and region specific and need also to take in to consideration the entire health ecosystem in that area. The specific challenges include:
    a. lack of sub-acute beds for patients who require rehabilitation, and a longer admission for recovery
    b. lack of non-acute beds required for those patients who need to transition from the acute care to home – either aged care facility, or home when they are able to do so with community services support and/or modifications to home for safe discharge etc.

2. Lack of workforce: Inadequate staffing in the THS, combined with the high reliance on locums, impacts on MON-FRI service delivery, even before there can increases discussion around afterhours activity. The workforce challenges include:
    a. Recruitment of Interns to the 3 major hospitals: shortfalls in recruitment result in the THS accepting last minute applicants from within the Australian University Medical School graduates, and/or having to recruit international medical (school) graduates (IMGs) from overseas.
    b. While the IMG pathway has enabled staffing of positions, IMGs require additional supervision. Teaching requirements are variable, can be resource intensive, and can require an extended period of appropriate support and supervision which directly impacts on afterhours rostering.
    c. Registrars: the THS has had a very high reliance on locum registrars. Locum registrars are necessary to fill vacant positions but are also expensive and not always available for the periods required. They also have an orientation/ familiarisation settling in period and are not around to follow up investigations etc when they depart.
    d. Specialist Medical Practitioners: The THS has had significant challenges attracting and recruiting key specialists in many areas, at all 3 major hospitals. This directly impacts on the workload of existing specialist workforce, and being frank, where units are unstaffed and under resourced the focus narrows to patient safety, to ensuring the minimum standards are met in all areas, and self-preservation to prevent patient harm and burnout. There can be no meaningful and sustained evolution of models of care delivery, let alone the expansion of services beyond MON-FRI 0800-1700 in this environment.
    e. Services beyond Monday to Friday 0800-1700 will have very limited capacity to expand beyond this given the current medical workforce staffing challenges and commitments that are needed to be meet in hours, with services beyond this effectively being emergency care

3. Lack of medical investigation capacity:
    a. The THS simply does not have adequate resources to keep up the demand for
        i. medical imaging (Xray, Ultrasound, CT scan, MRI, PET and other imaging) and
        ii. cardiac image investigations – echocardiogram, transesophageal echo etc
    b. These resources deficiencies include inadequate staff to operate the equipment- eg radiographers, sonographers, cardiac echo technicians / sonographers, and inadequate specialist doctors to report the Investigations
    c. equipment, old equipment that's hasn't been replaced and no longer able to be used to report scans (Medicare funded etc)
    d. This is due to a federal government to index the radiology medical investigations adequately which pushes more patients into the "Free" Public health system

e. THS emergency patients, and ward patients, are also in daily competition for access to medical imaging requests
f. Delays in investigations results in delays in diagnosis and clinical decision making, delays in escalation of care, delays in de-escalation of care, delays to hospital discharge, delays in referral to surgery, and patients can suffer adverse events (including advance of cancer from being local to invasive to metastatic, and death) where there is a delay in the diagnosis of a treatable condition.

4. Infrastructure: The future 2040 and beyond plans need to be funded, and commenced to be operational by 2035, not plans that are unfunded and not committed to.

5. **Our ageing population is perhaps the most critical challenge that we need to step up and prepare for:** We have clear data that there is an increasing and sustained growth in elderly patient presentations who will require in hospital care for medical conditions including operations. These patients are increasingly frail and complex. Any assumptions that these challenges can all be mitigated, and therefore require no additional resources, will result in a massive failure of government to plan and prepare for our increasing elderly patient demand. Specific care requirements include:
    a. appropriate spaces in ED – ie beds not chairs, and privacy
    b. appropriate specialists trained in geriatric medicine supporting ED
    c. appropriate investigation capacity to minimise any delays in ED and on the ward
    d. appropriate community aged care teams and access to community geriatricians to be able to provide community geriatric support- to minimise and prevent deterioration for treatable conditions
    e. improving elderly access to GP's when living at home or within aged care facilities
    f. sub-acute and non-acute beds for patients to be transferred into once the initial acute presentation and reason for admission has been treated
    g. appropriate resources and end of life decision making so that elderly patients are not transferred to hospitals when they are in the final stages of life but can be cared for appropriately and with dignity in the community, or the appropriate non acute / palliative facility and not experience a poor and undignified death in the ED's and in acute care hospitals.

6. The THS hospitals are the majority sites for elective surgery, and all have ED's. The constant demand to admit patients is coming at cost of access to procedures and surgery which are necessary. This is highlighted by the amount of public surgery that has been outsourced to private, and the real challenges with the blow outs in category 3 patients waiting for surgery, who are largely complex patients who are not fit for outsourcing to private and have been waiting for months to years longer than healthier patients who have been outsourced to private. These patients not infrequently present to ED needing emergency surgery or with complications from the condition that is yet to be treated.

7. All of these require a health budget that is funded for operational costs and indexed annual for increased demand, and not a budget that is determined by treasury.

Unless these larger systemic issues causing hospital bed block and discharge block are addressed, there will be no end to ambulance ramping without causing other harm to patients who are within the hospital system, and those on the wait lists waiting for their investigations and necessary surgery. The AMA does not see how the TOCP in its current form addresses these issues. The TOCP inserts Key Performance Indicators (KPIs) or targets onto a system that has access and discharge block, and these TOCP KPIs will become impossible to meet without other system reform. We would have been more comfortable with language within a TOCP that said the KPI's are necessary to monitor and report on ambulance ramping, and that the system is then accountable to address the

cause of access and discharge block. Without access, flow, and discharge improvements, the targets are impossible to meet going forward.

As it is, the RHH and LGH hospitals are struggling to meet the objectives and timelines as set out in the TOCP at peak periods. The AMA was willing to work with the government through the TOCP to ensure it was workable and didn't just add further stress to an already overstressed system. However, because of an industrial agreement with Health and Community Services Union (HACSU) requiring a mandatory process, this offer has largely been ignored.

The main change we wanted was to remove the mandatory elements within the Policy. For instance, within the introduction, the words 'Transfer of Care "**is**" to occur after 60 minutes' and under KPIs the words "with a 60-minute transfer of care remaining the **maximum timeframe** for when it is to occur…" remain which means it still is a mandatory requirement.

The only reason patients will not be transferred at 60 minutes is due to access block. Fix access block and you have fixed the problem. Without appropriate clinical places to put patients and without the adequate staffing to cover those patients, it is dangerous for some patients to be transferred out of ambulance care. We are concerned the TOCP simply transfers risk to an already busy, stressed, and worn-out staff, who when a patient has an adverse outcome while not being attended to, will be made to front a coroner's court to explain why. Patients need to be handed over to the right staff, to care for them in the right space (point of care) and should not have any decrease in care until this has been clinically assessed as being appropriate.

Monitoring ambulance ramping is not a solution - it merely reports the access block being experienced by the ED. It does not measure or report that the ED is providing appropriate care to the patients within the ED. The THS needs the government to provide the resources to improve intra hospital flow and discharge. Indeed, reduced Ambulance ramping is likely to see the same, if not higher volume of patients, presenting to the ED in shorter timeframes, as ambulances are available to respond quicker to clinical cases in the community. Even if the overall volume of presentations via Ambulance is likely to remain the same, it is likely to create a surge or peak in presentations to the ED, which then increases the demand on resources to manage, in a smaller time frame.

The government will point to changes being implemented such as:

1. *Bringing forward each discharge by a few hours, through better discharge planning, communication, and use of criterion-led discharge in and out of hours.*
2. *More use of transit lounges*
3. *Prioritisation of bed cleaning following discharge to enable rapid bed turnaround; this includes review of delays relating to cleaning out of hours and provision of additional resources if required.*
4. *Support from Integrated Operations Centres and inpatient teams to move patients from EDs to wards as quickly as possible, including through use of Interim Inpatient Management Plans as required.*
5. *Prioritisation of diagnostic procedures and attendant/orderly support for transport of ED patients.*
6. *Increasing capacity within our hospitals, through infrastructure upgrades, additional beds, and additional staff over the past two years.*
    - *The 2023–2024 THS bed opening profile was reviewed in late 2023, to ensure an appropriate mix of beds targeted towards areas of most identified need, including to support access and patient flow issues. The agreed profile delivered 68 beds, seven more than the 61 beds required to achieve the 298 bed target by 30 June 2024. The Deputy Secretary HPC has requested hospital chief executives to fast-tack recruitment to enable beds to open by June 2024 at the latest.*
    - *In the South, additional points of care have been implemented in the ED.*

- *The Department is negotiating with the Hobart Private Hospital to secure an additional 15 beds (on top of five existing cardiology beds) to create 20 sub-acute bed access for RHH.*
- *An eight bed GEM Hospital in the Home has commenced in the South*
- *In the North, 11 Hospital in the Home beds will be implemented from early April*
- *In the North West, the capacity of Medical C Ward has been extended to 15 beds*

The AMA notes that these are proposals and plans, and that the implementation of these measures is only part of the solution; ***it is not the entire solution***, and these do not justify or support a mandatory protocol. It is also important to note some of the resources pointed to by government simply do not exist yet to help address the impact of the implementation of the mandated protocol. Others like the additional points of care are in the process of being operationalised or has already been used to help meet preexisting demand, ***not address new demand.*** The AMA is also concerned about the ability to use the additional HPH beds effectively.

The prioritisation of diagnostic support for ED has direct impact on inpatients and outpatient diagnosis and flow. This prioritisation only adds to delays for investigations on inpatients, that is those in beds waiting for decisions on treatment options, surgical or non-operative, and delays discharge of inpatients. This impact on patient flow to create inpatient bed capacity, has been omitted in much of the discourse with government. This is a clear example of an unrecognised and unintended consequence from this prioritisation which has been proposed by an Ambulance focused response, not a system improvement to meet all demands on it.

It is critical the Integrated Operations Centre's (IOC's) funding and staffing is maintained to have appropriate decision makers rostered on to ensure that patient flow is continually being monitored and decisions made to prevent and reduced access block. Vacancy control could be detrimental to these management services.

The significant issues of sub-acute, non-acute and aged care facility access block outside of the acute hospital must also be addressed. At any one time, the RHH can have **20 or more** patients who are no longer an acute care patient but are occupying acute beds as there is simply nowhere else for these patients to be cared for. Likewise, the same issues are at the LGH, NRWH, and MCH. In fact, nearly 10% of the total statewide hospital acute bed capacity is occupied by patients needing aged care or NDIS services without appropriate placement options. That's 148 beds that could be freed up tomorrow if there was the appropriate place to move these patients. The patients awaiting NDIS or Aged Care assessment and approvals need subacute and non-acute beds to be transferred into while these approvals are being processed. These NDIS approval processes can take 6 or more weeks to be finalised. There are no clear funded plans to bring these beds online, and yet addressing this issue would have a dramatic impact on patient flow through the hospital. We urge the government to make the new sub-acute hospital facility at St John's Park a priority to help alleviate bed pressure at the RHH.

While work is underway with the National Disability Insurance Agency and aged care sector to reduce discharge delays that are clinically unnecessary, the timelines and outcomes of this are not clear, and as such as no reason to justify any mandatory protocols.

The AMA notes the implementation and expansion of alternative models of care to divert patients away from our EDs and hospitals, including through Hospital in the Home, virtual care/COVID@homeplus, urgent care clinics, direct admission pathways for some patient cohorts, Mental Health Emergency Response and working with the aged care sector to reduce unnecessary admissions from residential aged care facilities, are already underway or are being improved. We support these measures, but again note that these will take time to work up and implement and take effect and require whole of government support, especially from Medicare Funding (MBS items and patient rebates for GP and other specialist care including mental health etc) and Aged Care funding.

The AMA stresses that these are not alone going to be sufficient to address patient access, flow and discharge form the acute hospitals.

We are yet to see several of the recommendations from the *Independent Review of Tasmania's Major Hospital Emergency Departments* implemented to their full extent to see if they have any impact on the issues causing the bed block problem. It is critical adequate additional resources are allocated to assist patient flow throughout the hospital. If patient flow was properly resourced, the transfer of care protocol would not be required. The fact it exists is evidence of the failure of government to address the problems over many years.

Experience since the implementation of the TOCP

The Royal Hobart Hospital:

The ability of the ED to comply with expected TOCP standards is entirely reliant on the hospital capacity to function. A measure of how well a hospital is functioning is the reported escalation level each hospital is at. Escalation levels of 3 or 4 means that the hospital is above capacity and measures are required to improve access and flow. These measures regularly include cancelling surgery and other procedures to prioritise flow of Patients from ED into the hospital, and to get emergency patients needing surgery into theatre earlier, at the expense of elective or booked patients. At levels 1 or 2 they have been largely able to comply. Noting in recent weeks we have moved to a Statewide 3-tiered system. The AMA Notes that the level 4 was specifically created at the RHH because of the pressures within the RHH that lead to "internal disasters or code yellows" being called, and this was politically embarrassing to have the RHH declaring a code yellow.

To improve this, improvement in efficiencies within hospital systems, as well as additional hospital bed stock is needed. But most importantly for improvements to be sustained they need meaningful resolution to hospital exit block i.e. subacute and nonacute bed stock in the community and boosted community services.

Data reporting remains problematic with ambulance reporting seemingly not consistent with data from real time observation and Trak information. To understand the problem, there is a need for investment in clean data capture systems that allow ambulance and hospital systems to transparently talk to each other.

EDs are not choked with GP type presentations. A very small percentage (<2%) of ED presentations could be entirely managed by a GP in the community. The message that EDs are being overcrowded with GP type patients is incorrect. The narrative that urgent care centres are making a meaningful impact on ED presentations is optimistic at best. UCC's may stop around five patients a day going to the RHH ED.

Ambulance offload to the waiting room processes have had minimal effect on TOCP, as this was already occurring at RHH before the protocol.

The reality is Ambulance Tasmania (AT) presentations will not decrease because of the TOCP and access block will continue without meaningful resourcing. RHH senior executives are engaged in seeking access and flow improvements. This is however a very complex task due to under-resourcing, culture and competing service demands. Change will be slow. A protocol of itself is not going to improve access and flow in the hospital and more importantly out of the hospital, which holds the key to the problem.

The Launceston General Hospital:

The Launceston General hospital routinely has patients in ED for longer than 8 hours, and on a daily basis holds admitted patients for greater than 24 hours. With space in short supply, it is not

uncommon to have patients on stretchers in corridors, receiving a lower level of nursing and medical care than is optimal because of the lack of space and staff to provide care.

Following the implementation of the TOCP, the LGH is accepting patients earlier and filling the front end of ED with ED patients. The airlock has become an ED holding bay rather than an ambulance holding bay. Waiting room medicine is becoming a normal activity and extending significant risk into an unmonitored area.

The ED staff have changed their mindset and accept that patients arriving by ambulance or walking in are ED's business. The long stay admitted patients are the problem. But in accepting this responsibility there is an added burden on the ED with increasing numbers of patients waiting in inappropriate clinical areas around the ED and more and more medicine being carried out in the waiting room. This is a compromise in how and where care should be delivered.

There is significant clinical risk in the waiting room as ambulance patients are potentially preferentially off loaded while acute patients wait in the waiting room. The nursing allocations have been changed to support an ambulance triage nurse and an offload nurse. These allocations are dependent on staff numbers on the day and with the significant pressure on nursing rosters staff can be spread thinly around the ED. The LGH has also commenced a nurse navigator role which has been created from existing FTE.

There have been no additional resources to support the TOCP and access and flow initiatives around the hospital. There is significant work to be done in the hospital system to manage access and flow much of which has been detailed in the recent Piccone ED Review. There is an active conversation each day regarding expected dates of discharge, discharges before midday, use of the transit lounge, utilisation of unoccupied HITH beds, district hospital beds, and privates. Despite this the ED is more access blocked than ever with increasing numbers of patients remaining >24 hours in ED. Recently, as an example, there were 14 patients remaining in ED > 24 hours one week and the ED reached 10 > 24 hours in the following week. This is absolutely unacceptable in most ED's on the mainland. As we know this problem is not an ED problem, rather a result of the dysfunctional flow through the hospital and out into the community (exit block). The LGH is by far the poorest performing hospital in the State due to the long stays in ED.

Overall, because of the TOCP there has been some shift in the conversation, but we are yet to see improved access and flow through the system.

The North West Regional and Mersey Community Hospitals:

The TOCP and the ED review have provoked more discussion and focus on access and flow at both sites, however, there have been no new resources allocated to support patient flow initiatives and there has been inconsistent executive pressure on potential levers such as time from previous patient discharge to ED transfer to ward bed. There appears to be a paucity of granular data available to support collective analysis of why patients are not meeting EDD or being discharged early in the day, or why a bed is not available. Early discharges are chronically hampered by a significant reduction in JMO staffing and no redundancy in inpatient registrar capacity. There are large proportions of inpatients who sail far past their EDD due to lack of NDIS or aged care infrastructure to support them at home or in an appropriate residential bed. Weekend discharges remain up to 20% of those on other days.

TOCP cannot occur unless there is a clinically safe space available for the patient. As no additional clinical spaces have been provided, there has been no change in the ED experience following the TOCP implementation. However, ramping has not been as significant a problem in the NW and the NWRH and MCH generally met the initial target. The higher targets will become more challenging.

While the TOCP has not changed the landscape of itself for any of the hospitals, there is a hope that the Picone ED Review will lead to better resourcing and operationalising of services that will address the challenging problem of ambulance ramping with a whole of system lens.

We need to be mindful the data collected around ramping doesn't reflect reality. It is a signal only. For instance, the mean time difference between actual transfer of care (patient physically off stretcher and handover complete) and AT clinician reporting off-stretcher to comms can be quite different, distorting the data. Having consistent collecting of data between AT and ED would help.

Review into the State Hospitals Emergency Departments

The AMA Tasmania Branch met regularly with the primary author of the *State Hospitals Emergency Departments Review*, Ms Deb Picone, to be updated on the progress of the review and to hear our views. The significant challenges facing emergency departments were clearly understood by the review team, however, some of the recommendations to come out of the report are overly ambitious, some only go so far in addressing critical areas such as staffing challenges, and some serious pressure points for our healthcare system have been completely overlooked.

Ask any emergency department doctor about their biggest frustration, and they will tell you it is getting patients admitted into an in-patient bed. Ask any hospital physician, and they will tell you it's not having appropriate sub-acute care beds to move patients into to free up acute beds for the unwell stuck in emergency departments. The human toll of bed blocks is a daily reality they grapple with.

To alleviate the strain on hospital bed capacity, immediate steps must be taken to increase nursing and medical support to residential aged care services, improve NDIS services, and establish integrated primary health care services for individuals with chronic and complex physical and mental health conditions.

The government needs to focus significantly on subacute and frailty care, including bringing forward the building of a new subacute facility at St John's Park. The urgency of freeing up beds cannot be overstated. Many of these sub-acute patients could be stepped down into temporary care facilities while building of a new facility takes place.

We note that issues surrounding aged care and NDIS, from workforce shortages to financial sustainability, are issues primarily for the federal government, but the state can help too in various ways. What we don't want is more finger pointing and inaction.

Where the review has fallen short is overlooking areas of critical shortage of various types of beds and services in Tasmania. For example, while the report acknowledges the importance of expanding the Hospital in the Home or GEM@home programs, (we need at least 100 more beds), it failed to address the implementation of specialised geriatric care in the hospital, a significant oversight given that Tasmania has the highest population of older people in Australia.

AMA Tasmania has put forth a comprehensive plan for subacute and low acuity care implementation. This includes the use of supplemented bed in Medi-hotel environments with recruitment and retention of appropriate staffing, utilisation of community hospitals' subacute beds, and support for patients in their homes by other community health providers.

The review fails to highlight the critical role of all staff in managing patient flow within our healthcare system while also exposing deficiencies in several key areas. These shortcomings include inadequate capacity to manage tests, results, and patient reviews, as well as insufficient staffing across key hospital departments across the state. We cannot afford to focus on flow management and staff governance without emphasising operational aspects to ensure effective and efficient healthcare delivery.

Expanding the scope of practice of other healthcare providers is not the panacea. AMA Tasmania must be involved in any decisions about changes to clinical care provided by other healthcare providers and not doctors. Doctors are highly trained and cannot be substituted by other healthcare providers without increased patient risk. However, where key integrated areas of delivering healthcare in Tasmania work together for instance, Ambulance Tasmania identifying areas where there might be safer and more efficient ways to deliver care to Tasmanians are welcomed.

Record-long wait times for planned surgeries and ongoing challenges in emergency departments underscore the urgent need for action. Access and affordability issues in primary care further exacerbate the situation, with the recent announcement of several key general practices across the state closing or amalgamating adding to the pressure, requiring an improved model of better employment conditions for general practice trainees, funding rebates for patients and improved workforce planning.

We continue to call on the state and commonwealth governments to collaborate to expedite necessary reforms and allocate resources to bridge the funding gap across all services. The only way to fix our emergency departments is to address health system capacity and patient flow through collaboration, innovation, and investment to meet current and projected demands. This is crucial to ensure the delivery of high-quality and accessible healthcare services to all Tasmanians.

RHH ED redevelopment

A threat to the redevelopment plans of the RHH ED has also arisen since the implementation of the TOCP and the release of the Review into EDs. Plans for a major expansion of the RHH's ED have been reduced due to budget constraints and a blowout in building costs.

We understand revised plans are being developed which will see a smaller ED with fewer treatment points being built than initially planned to deal with increasing demand. Therefore, the RHH will no longer have a fit-for-purpose ED that can meet current demand, let alone the increasing demand we know is coming over the next decade and beyond.

Delivering a cut-down redevelopment and using substandard space to compensate is not building the infrastructure Tasmanians need now, let alone in ten years. The last thing we need is for taxpayers' money to be used on a facility that is not fit for purpose.

The reality is that any revision will not deliver the increased ambulance bays required to reduce ramping or the increased number of lay-down beds needed to meet today's demand.

We believe an old ward, known as Ward 3J, meant to be used as a decant space while the redevelopment occurs, will become a permanent part of the ED. This space does not meet modern guidelines for patient safety, patient privacy, and the requirement to be co-located with an ED.

The increase in cost is largely due to nationwide rises in building expenses, as well as complexities associated with constructing on a brownfield site. We need to be clear, any cost-cutting alternative will compromise patient health and put frontline healthcare workers at risk.

Anyone who has been to a public hospital emergency department recently knows they'll be in for a long wait before they will be seen by medical or nursing staff, who are trying to do their best to see patients in an over-crowded facility. A modern purpose-built ED, designed to handle the diverse range of patients who need urgent care, is essential for our healthcare system.

A supportive work environment is not a luxury but a necessity for nurses, doctors, and all medical staff. It enables them to provide patients with the best care and maintain their well-being. It is crucial that their workplace meets the highest health standards.

Healthcare is not just a cost but an investment in our economic productivity. Healthy individuals are more likely to work, contribute to society, and reduce the need for expensive medical interventions. Good health is foundational to a thriving economy.

The AMA can't stand by to watch an expensive substandard redevelopment occur because the government is not prepared to find the extra $50m to finish the project. Investments in infrastructure that supports the health of our community must be the government's priority.

Tasmanian Health Senate

The AMA fundamentally believes that the challenges facing our health service are so complex, broad, and politically dynamic, that it is appropriate for the Tasmanian Health Senate to be given the task to advise Government on what it must prioritise to address access block and enable a non-mandated TOCP within 60 minutes, reducing to 30 minutes, to be achieved over time.

The solutions are not quick and easy political announcements, promises or commitments made at election time, or Enterprise Bargaining deals made between unions and the Government.

We believe the Tasmanian Health Senate should be tasked to oversee the work of the Picone review into ED, as well as ensure recommendations from the Parliamentary inquiry into Transfer of Care are enacted.

In addition, the Senate could identify other issues preventing consistent patient flow through the hospital and work with hospitals to develop and implement solutions to enhance patient flow. These solutions will require a commitment to additional funding from Treasury. Only with appropriate funding of the solutions will we be able to prevent Ambulance Ramping and achieve non mandatory Transfer of Care protocols within a set timeframe.

Medical Workforce

The THS faces significant challenges attracting doctors at all levels, and the complexity with managing and providing a services overly reliant on expensive locums also has clinical risk with lack of ongoing continuity of care, and gaps in service provision. This leads to delays in diagnosis, delays in commencing treatment, and delays in discharge, not to mention the delays in completing administrative tasks which include communication and discharge summaries. Any delays to appointing candidates often sees high quality candidates go elsewhere. Vacancy control has the risk of decreasing the quality of healthcare workers, the quantity of employed healthcare workers, increasing locum reliance and locum costs, and increasing the likelihood of adverse events.

Conclusion

The AMA Supports the introduction of a Transfer of Care Protocol, but this protocol must not be mandatory. The current TOCP still requires mandatory transfer of care of patients to the EDs. Nothing has changed. It is doomed to fail without the resourcing needed to help patient flow. Existing bed floor, executive and ward management staff are already aware and trying to manage flow issues. It is unclear how adding any more pressure onto those key staff will help, other that make for an even more stressful work environment.

The only way to fix ambulance ramping is to for the health system capacity and patient flow to be addressed to meet current and projected demands, through collaboration, innovation, and investment, not a mandatory TOCP.

AMA Tasmania branch supports carefully considered and appropriately resourced initiatives to solve not only ToC but access block more generally. We support non mandated targets linked to improvements in access block and patient flow. The ToC protocol and associated small increases in

resourcing do not adequate address system issues to allow successful or sustainable improvements in patient flow.

We have genuine concerns that without appropriate investment, the TOCP will result in patient and staff harm as well as organisational reputational injury. Therefore, AMA Tasmania branch wants to see ramping of ambulances addressed through:

1. Root cause analysis of Ambulance ramping to identify the Whole of System contribution factors
2. Tasmanian Health Senate to work with Department of Health to develop workforce and infrastructure recommendations to address access block across the hospital system,
3. A clear strategic workforce and infrastructure plan be agreed to by Government Government commitment to funding, resourcing and implementation of the workforce and infrastructure recommendations

Thank you for the opportunity to contribute further to the Parliamentary Inquiry into Transfer of Care Delays.

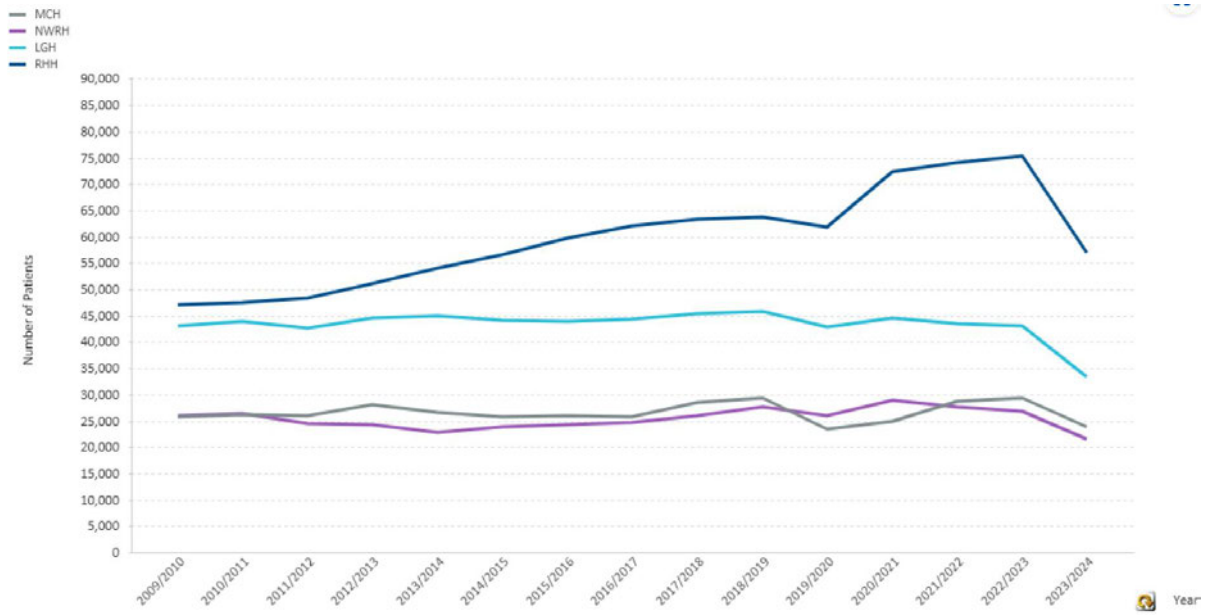
Your sincerely

Dr Michael Lumsden-Steel
President AMA Tasmania Branch

Background Emergency Department Data

The following data is important to show the worsening situation in our Emergency Departments – noting the 2023/24 data is incomplete and should not be read as trending down.

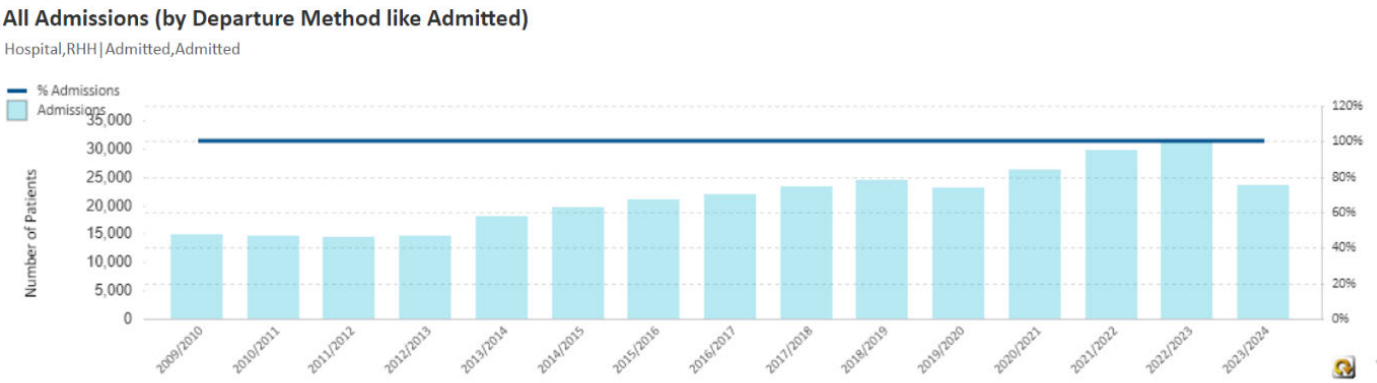
Emergency Department Presentations:



For 2023, ED presentations statewide are approximately 175,000:

- RHH 76000
- LGH 44000
- MCH 30000
- NWRH 27000

Hospital Admission rates by presentations:



- RHH 40%
- LGH 35%
- MCH 35%
- NWRH 30%

Hospital Presentations by Ambulance:

Ambulance Ramped > 15 Mins vs All Ambulance Arrivals

Hospital,RHH

Year	Hospital	Ramped >15 Mins	Ambulance Arrivals	% Ramped > 15 Mins
2014/2015	RHH	1953	19 304	10%
2015/2016	RHH	2074	20 398	10%
2016/2017	RHH	3314	20 631	16%
2017/2018	RHH	6570	21 728	30%
2018/2019	RHH	7762	22 698	34%
2019/2020	RHH	7088	22 300	32%
2020/2021	RHH	8618	25 106	34%
2021/2022	RHH	10989	25 358	43%
2022/2023	RHH	12410	25 418	49%
2023/2024	RHH	9095	18 843	48%

* Ambulance arrivals and ramped count from this section are based on the seleted date either ED arrival or departure

The RHH: On average approximately 210 presentations to RHH per day, on average 68 via Ambulance and 145 walk ins. (a 1/3 v 2/3).

LGH – 15000 ambulance presentations per year (average over 3 years) – or 41 per day

MCH 4600 (average over 3 years)- or 13 per day

NWRH – 8600 (average over 3 years) or 24 per day

Time Patients spend in ED:

The data confirms that patients requiring admission are spending too long in our Emergency Departments.

Requiring admission left ED for a ward within 4 hours (running average 2 years): the Expected Target of achieving this is 60%

- RHH – approx. 10%
- LGH – approx. 10%
- MCH – 15-20 %
- NWRH 15 %

Requiring admission left ED for a ward within 8 hours (running average 2 years): Expected Target 90%

- RHH – approx. 40%
- LGH – approx. 30%
- MCH – 50 %
- NWRH 45 %

Requiring admission left ED for a ward within 12 hours (running average 2 years): Expected Target - 100%

- RHH – approx. 55%
- LGH – approx. 50%
- MCH – 50-70 %
- NWRH - 65 %

As a contrast, patients not requiring admission (ie patients ED staff can discharge) are managed closer to the agreed target or exceed it: National Target is 60% have a LOS less than 4 hours

- RHH 58.98 % (Nat Target 60%)
- LGH 52%
- MCH 84.7%
- NWRH 73.20%

The Issues

Australia has an ageing population, and Tasmania's is ageing faster than most, with the result the demand for acute beds is outstripping supply. The AMA Public Hospital Report Card data, backed up by our survey, shows the decline in the number of public hospital beds per 1000 population aged 65 years and over combined with the rapidly aging population is why ramping exists.

Number of approved/available public hospital beds per 1000 population aged 65 and over -all States and Territories

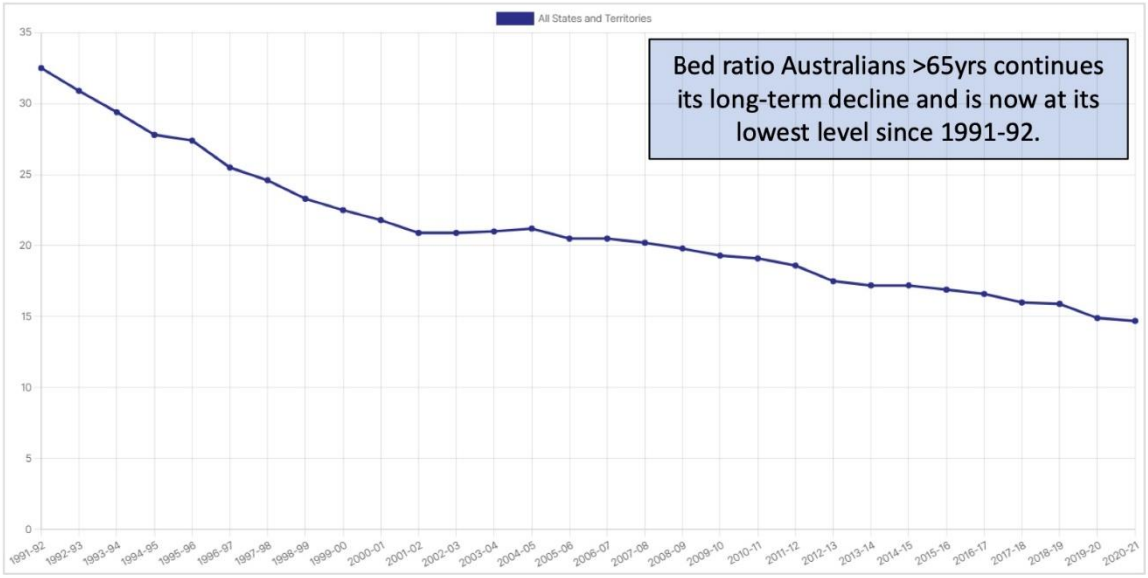


Figure 3: Australian Bureau of Statistics, national, state and territory population, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-download

Figure 3 shows that in 2020–21 the ratio of total public hospital beds for every 1,000 people aged 65 years and older was 14.7 — a decrease of 0.2 per cent from the previous year (2019–20).[14] This is in spite of the fact that overall number of public hospital beds increased by 1.2 per cent in 2020–21 compared to the year before.[15] This ratio has now been on a downward trend for 27 years and is a major cause of public hospital over-crowding and long waiting times for emergency and planned surgery treatments.

To state the obvious, ramping is occurring because the hospital is full. A mandatory Protocol exposes hospital systems that by definition do not have adequate patient capacity to meet demand and therefore impact patient flow. The net effect is a log jam in the emergency department with backflow onto the Tasmanian Ambulance service.

A mandatory Transfer of Care Protocol might achieve ambulances release after 60 minutes, it does not fix the Hospital issues that sit behind the problem of ramping. What it does do is force patients into already full Emergency Departments, adding to the stress of a workforce struggling to give the care required to all in need.

For any TOCP protocol to be implemented and be achievable without compromising patient care or adding more stress to an already stressed system, the hospital and community health system must be appropriately funded. It is imperative that government supports, funds and implements measures to fix access block to ensure the TOCP does not cause more harm than good to patients and staff.