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

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We make this submission because we are vitally concerned to see tangible improvements to transfer of patient care in Tasmania. Previous inquiries over the last decade (Valentine Parliamentary Inquiry; Auditor General; Newnham/Hills Inquiry) have addressed many of the issues that currently contribute to the critical situation impeding adequate (let alone best practice) transfer of patient care in the State.

In terms of the current request for submissions to the House of Assembly Select Committee on Transfer of Care Delays we address the Terms of Reference as follows:

(a) The causes of transfer of care delays acknowledging Federal and State responsibilities:

The causes are multifaceted, and most stem from State responsibilities not being adequately upheld. In relation to those State responsibilities, we identify the following three stages at which systemic issues left unaddressed (despite the high-level inquiries cited above) lead to ambulance ramping.

First, there are far too many unnecessary admissions to ED including nursing home patients/residents, and other elderly patients with chronic and acute health concerns that can be effectively assessed by other agents. Our submission focuses on these admissions because they represent the number 2 cause of hospital presentations in Tasmania and Australia-wide namely, those diseases associated with ageing - neuro-degenerative diseases including dementia (especially Alzheimer's) and Parkinson's.

For these patients, rather than relying on the Ambulance Service, the current Rapid Response Team (RRT) should be expanded to cover the State. This team makes excellent assessments of patients in both home, and nursing home contexts thereby keeping patients out of hospital. In addition to this, the Hospital in the Home (HiTH) service should be expanded. Again, this is currently geographically limited which given the benefits (health and economic) of this service, is perplexing.

Further to this, many nursing homes are currently unnecessarily reliant on the ambulance service when a patient becomes ill or has a fall. Many of the current calls to the ambulance service could be averted if nursing home clinical staff were able to refer patients to the RRT. Now, nursing homes must rely on a GP for a referral to the RRT. Clearly this is not a functional situation. Giving clinical staff the ability to refer to the RRT would resolve this.

The effective implementation of the RRT and HiTH - two community-based health services - as preventive clinical initiatives would prevent many unnecessary ambulance calls and trips to ED.

Second, ambulance ramping and ED admissions could be further reduced by the deployment of senior clinicians and a geriatrician in ED to make a rapid assessment of patients to determine immediate care required, and the appropriate site of that care. Far too often the hospital staff contacted by junior ED doctors do not have the experience to make such rapid assessments particularly, of elderly patients.

Third, ambulance ramping and ED admissions are also an outcome of poor discharge planning. This is also something that can be easily remedied. Discharge planning for patients admitted to hospital from the ED should start on the day of admission when goals of care are determined. The admitting team should also be the discharge team, so as to ensure continuity of patient care, accountability, and transparency. For older people, there is a limited range of goals of care, including rehabilitation; cure of acute illness and return home; palliation; and nursing home placement. If for example, the goal of care is deemed to be nursing home placement, then team liaison with the patient's GP, and family/guardian/decision-maker should be commence at the point of admission, and an appropriate nursing home identified. It should be a quick matter to obtain an ACAT assessment where one is needed, as there are associate ACAT assessors in the hospital. Contrary to common belief inside the hospital, nursing home beds are available. Managers of nursing homes are often reluctant to accept transfers from hospital, however, because they find that the information received from the hospital team is unreliable and misleading. The lack of follow-up when their new residents prove to be a challenge is a major problem. And hospital geriatricians, and Mental Health for Older Persons do not provide assistance on an urgent basis when this happens. If the admitting team were to ensure that each patient with dementia had:

- A diagnosis (where relevant) of dementia or delirium

- A capacity assessment for matters such as decision-making about accommodation, health management and care. And where relevant the appointment of a surrogate decision-maker, whether a guardian, power of attorney or person responsible.
- End of life plans

(b) The effect transfer of care delays has on:

(i) Patient care and outcomes:

Longer stays in hospital; deconditioning of patients who are often discharged in a worse state than they were in when admitted; readmissions; loss of public trust in the health system. General practitioners and nursing home managers have largely given up on trying to obtain information about their own patients, and are often told that they can be told nothing "for reasons of privacy and confidentiality"!

(ii) **Ambulance Response Times and Availability:**

Again, these are an outcome of poor practices within the hospital that have far too many patients occupying beds on wards without any discharge planning having been undertaken. Ambulances ramp in this case, and their response times blow-out because there are no beds in the hospital to take patients (bed-block). There are no beds in the hospital to take new patients because there is no effective coordination between ED, relevant hospital clinicians (in the case of the many elderly patients this is geriatricians of which there are approximately 13 at RHH), nursing and allied health staff, patient's family/guardian/nursing home to ensure appropriate and timely care and discharge.

Ambulances also ramp as mentioned above because too many elderly patients currently must rely on this service (either via transfer from their nursing home or own home) when the use of the community-based services of the RRT and HiTH is far more appropriate and would see better health and cost outcomes.

(iii) Wellbeing of healthcare staff:

This is very poor as the reports cited above testify. The reasons for this are clear and have to do with all the issues raised in our previous points. That is, there is a system-wide failure both at the site of the major hospital (RHH) specifically, and the health care system more

generally to ensure the implementation of functional processes that are transparent, accountable to all stakeholders, and which are patient-centred. The failure to implement transparent systems and procedures as well as the absence of a clear system of governance (the RHH has no independent governing board, for example) has seriously undermined staff morale and trust in hospital management. Most hospital staff seriously seem to think that the problems relate to inadequate staff numbers. We maintain that the reason is poor hospital culture which seeks to address the needs and wants of staff (frequent changes in treating team, lack of consultation with families and nursing home, lack of follow-up) and not the needs of the patients and their families. Change-agents are not always welcome on hospital staff.

(iv) Emergency Department and Other Hospital Functions:

As we have stated above, the ED and hospital functions lack coordination, transparency and any semblance of good governance based on a best practice model of patient-centred care. Further to this, the hospital currently operates on a general medicine model of care for almost all medical (as opposed to surgical) patients. This is inappropriate for patients in the number 2 category of cause of illness and death in Tasmania and Australia-wide namely, those diseases associated with ageing- the neurodegenerative conditions including dementia (90%) but also Parkinsons, motor neurone disease and so on. The care of these patients needs to be replaced by community-based care which would require the following:

- A community-based team of geriatricians, nurse practitioners, allied health, and administrative staff. This state-wide team could assist general practitioners to provide care to the elderly, including in nursing homes. All too often this is only addressed with hospital presentation when there is a crisis. Palliative care provide a responsive service to nursing homes. Mental Health for Older Persons, on the other hand, (along with geriatricians) have expertise in the most difficult dementia symptoms- the behavioural and psychological symptoms of dementia [BPSD]. Unaddressed, these symptoms can require long hospital admissions (months and months). Mental Health for Older Persons are also the gate-keepers to the Roy Fagan Centre which is the state-wide psychiatric in-patient service for older people. This service rarely even acknowledges referrals from general

practitioners and nursing homes, and does not provide a responsive, accountable or mostly acceptable service.

All the necessary programs and services to achieve this already exist in some form (RRT, HiTH, Integrated Operation Centres (IOCs), nursing home care, community nursing, Mental Health for Older Persons, etc). However, there is no effective resourcing or coordination of these into a single, community-based health care system (see detail on this below at (f).).

In relation to the RHH we argue that 3 'quick wins' can be achieved in relation to transfer of care delays:

1. Schedule daily consultant geriatrician rounds through the RHH ED to:
    a. establish goals of care;
    b. facilitate admission diversion plans;
    c. plan follow-up in nursing homes or the community;
    d. establish the decision-maker (patient/ family member/ guardian) .
2. Consolidate the Acute Older Person's Unit and Aged Services (AST) into a single Geriatric Medicine Ward/Unit. Staffing of this unit to be comprised of geriatricians, nursing and allied health staff. Continuity of patient care from admission to discharge needs to be paramount. An admission consultant from day 1 should remain the consultant throughout the patient stay.
3. We stress that the families and community-based carers of geriatric patients admitted to hospital must be incorporated into the charting of a patient history, care plan and discharge planning. In relation to neurodegeneration, the patient history is necessary for diagnosis, and the family and carers are critical to this. Patient histories constructed this way will avoid unnecessarily lengthy hospital stays thereby also resolving one of the main causes of ambulance ramping.

(c) The Adequacy of State Government's Data Collection and Reporting for Transfer of Care Delays:

If data collection and reporting is taking place, then the system and processes used for this are entirely opaque. The online systems, Best Med and EMR are currently not coordinated and not accessible by staff outside the hospital system (ie, in the community sector), and yet effective access and coordination of these systems across the Tasmanian health system is critical to any resolution of transfer of care delays and ambulance ramping.

We argue that the role of the Integrated Operation Centres which currently enable patients requiring acute hospital care to be transferred around the State be expanded. If expanded, the IOCs could also play a crucial role in facilitating intermediate care for complex geriatric patients. These centres could become clearinghouses for patient flow and capacity data across all non-acute care settings including, nursing homes, residential care facilities, district hospitals, Hospital in the Home (HITH) services. *Best Med* and an integrated EMR system could therefore play a critical role in the operations of the IOCs to ensure timely flow of patients with appropriate medication from hospital to their subacute care setting. Currently, the inaccuracy of data on bed availability in the state's hospitals and nursing homes is a major source of transfer of care delays, ambulance ramping, patient suffering and bed-block. The relevant IT systems need immediate and effective upgrading.

The RHH geriatric team and the IOcs should establish a system and procedure for flow of patient date/ information and discharge planning.

(d) The State Government's Response to transfer of care delays and its effect to date, and the efficacy of these measures.

HitH is one initiative that has worked very well. However, it is limited geographically, and by the other system-wide issues described above.

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

The Select Committee needs to look no further than the 2019 review of patient access at RHH conducted by Professor Harvey Newnham, and Associate Professor David Hills, titled, *Towards Outstanding Care at the Royal Hobart Hospital* (Appendix 1). Best practice from Australian and international hospitals is discussed in this review. It also contains a comprehensive account of the full range of issues at RHH limiting patient access and causing ambulance ramping. As well as making detailed recommendations for both long-term and immediate change at RHH the review also provides a detailed summary of the recommendations of all previous reviews into patient access

at RHH. A copy of this review is appended here for the Committee's information.

(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.

In addition to our suggestions above, the short, medium, and long-term recommendations made by the Newnham- Hills Inquiry (Appendix 1) should be implemented in full.

We attach the Newnham Hills Inquiry (Appendix 1) together with two additional documents documents which provide further context and detail that supports our submission (Appendix 2 & Appendix 3).

Once again, thank you for this opportunity to make a submission to this critical Parliamentary Select Committee. We would also welcome the opportunity to speak with the Committee to provide clarification and further evidence.

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