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for Emergency Medicine

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Submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) – July 2024

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to make a second submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) Inquiry (the Inquiry). ACEM commends the Select Committee for continuing the vitally important work of the previous Parliament.

ACEM has a long-standing interest in acute health system function, in particular hospital Emergency Department (ED) overcrowding, long ED wait times, and the management of patient flow throughout hospitals. Transfer of care (TOC) delays (ambulance ramping) and access block is a symptom of a health system in crisis. Access block is the single most serious issue facing EDs and the major contributor to ED overcrowding and TOC delays.

ACEM recognises the importance of ambulances being available to respond to emergencies in the community rather than being stuck outside a hospital. Our submission builds upon and reinforces key messages that were provided in the College's previous submission on 13 October 2023 (Appendix 1).

Year-upon-year, Tasmanian hospitals are experiencing worsening performance in TOC delays, waiting times, hospital lengths of stay and poorer patient outcomes. A whole-of-hospital and whole-of-system approach, coupled with increased investment in hospital and community-based services is desperately needed if the government is to successfully address the health system crisis.

1. The impacts of access block and transfer of care delays

ACEM notes that TOC delays are a very visible problem, often referred to in the media and part of public discourse. Importantly, ACEM also recognises this is not a new problem, with access block and TOC delays identified in numerous government consultations and audits in the past.

Access block is defined as the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than 8 hours because of a lack of inpatient bed capacity. This also includes patients who were planned for an admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED.

Access block and TOC delays caused by bottlenecks in other parts of the healthcare system have implications for patient safety. To put it simply, when EDs are access blocked due to hospital capacity, patients are at greater risk of dying and there is an increased risk of medical errors or of conditions being missed. The training and education of junior healthcare workers is also severely compromised, with the inter-professional conflict that emerges within the hospital environment increasing stress and decreasing job satisfaction, leading to higher rates of attrition and burnout.

2. Rapid offload policies

The interaction and handover of patients between the ambulance services and ED staff is critical to ensuring that patients receive the correct treatment in a timely fashion. ACEM members report that

their interactions with ambulance services are professional and that paramedics provide high-quality care within their scope of practice. However, TOC delays challenge the traditional 'respond, stabilise and transport' focus of ambulance services and raises an ethical dilemma for paramedics, who are effectively being asked to continue to provide ongoing emergency medical care for the patient beyond the scope and time frame of their expertise.

Whilst ACEM recognises the different imperatives of ambulance services and ED teams, the College does not support policies that allow for ambulance services to leave a patient in a transition area when there is no capacity within the ED to care for that patient. There have been occasions in other jurisdictions where ambulance services have trialled a 'rapid offload' model-of-care, whereby patients are left at the ED door without any transfer. In that model, ambulance staff cease to continue emergency medical care so that they can respond to other emergencies in the community.

Hospitals and EDs are already facing extremely high levels of demand and are staffed by a workforce that have endured unprecedented levels of pressure amidst the backdrop of a global pandemic, an exodus of senior healthcare workers, and chronic vacancy and recruitment issues. They also face the daily moral injury of wanting and being trained to help people, but being placed in a situation of being unable to do this to an appropriate level. This means rapid offload is a highly dangerous response, that will lead to greater harm and fewer patients receiving the care they need in a timely fashion.

Emergency physicians are deeply concerned that rapid offload policies becoming business as usual will soon lead to the return of 'corridor medicine' as part of their daily expectations, that patients in the waiting room will effectively be ignored in preference to patients in an ambulance and that non-clinician executives will attempt to direct clinical care.

3. Update on the Transfer of Care policy

ACEM wrote to the Minister for Health, the Hon. Guy Barnett MP on 31 May 2024 to express concerns about the mandated 60-minute TOC protocol. The College is extremely concerned by the government's framing and approach to the issue, as 'banning ramping' does not address the underlying issues that lead to ramping

Largely, ACEM's members report that the new mandate has had minimal effect on the operations of EDs and the broader hospital. TOC delays are reduced when there is flow throughout the hospital – however, whilst access block and overcrowded inpatient wards persist, there is very little that the mandate can do in these situations.

Our members have reported that the mandate has led to an increase in inter-professional conflict, where you have one party wanting to offload the patient, whilst the other party feel it is unsafe. The TOC mandate has increased the administrative load of ED staff, and ultimately, healthcare workers believe such arbitrary measures simply ignore the key issues that perpetuate the long-standing health system challenges in Tasmania.

4. Contact

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Hamish Bourne, Manager, Policy and Advocacy (Hamish.bourne@acem.org.au).

Yours sincerely,

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Submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) Inquiry

Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to make a submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) Inquiry (the Inquiry). ACEM acknowledges the importance of ambulances being available to respond to emergencies rather than being ramped outside a hospital. The College stresses that ambulance ramping is symptomatic of broader healthcare system inefficiencies and cannot be resolved without commitment and collaboration from all parties that looks beyond immediate political pressures.

Our submission outlines that the Tasmanian Government must focus efforts on addressing all systemic pressures across Tasmania's broader healthcare system to rectify the ongoing and increasing pressures of ambulance ramping.

About ACEM

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in emergency departments (EDs) across Australia and Aotearoa New Zealand, training emergency physicians in these regions, and accreditation of EDs for emergency medicine training.

Definitions

2.1 Ambulance ramping

Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED[1]. In some jurisdictions, ambulance ramping is also referred to as 'off-stretcher time delays' or 'ambulance turnaround delays'.

2.2 Emergency department overcrowding

Emergency department overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical or staffing capacity of the ED, whether patients are waiting to be seen, undergoing assessment and treatment, or waiting for departure[2].

2.3 Access block

Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the emergency department (ED), whose total ED time exceeds eight hours

[1] Australasian College for Emergency Medicine. Position Statement on Ambulance Ramping (S347). Melbourne: ACEM 2018

[2] Australasian College for Emergency Medicine. Position Statement on Access Block (S127). Melbourne: ACEM 2018

because of a lack of in-patient bed capacity. This includes patients who were planned for an admission but were discharged from the ED without reaching an in-patient bed, or transferred to another hospital for admission, or who died in the ED[3].

2.4 Off-loading

Ambulance off-loading refers to an agreed process between ambulance services and ED staff when transferring patients from the ambulance stretcher into an appropriate area within the ED[4].

Submission

General comment

ACEM recognises the vital role ambulances play in patient care, including by providing essential emergency response services that stabilise and transport patients to EDs. In 2021/22, there were 173,276 ED attendances in TAS, of which 54,183 patients arrived by ambulance, air ambulance or helicopter rescue service (31.2%)[5].

ACEM considers that ambulance ramping is a symptom of a health system in crisis. When patients in the emergency department (ED) cannot be admitted to in-patient care due to a lack of available beds (referred to as access block), the ED does not have capacity to accept new patients, including those arriving in ambulances[6]. ACEM considers that access block results in poor health outcomes for patients presenting to EDs, as it prevents patients from receiving the timely care they need. Research has shown that a patient who arrives at an ED which is 10 per cent access blocked has a 10 per cent greater risk of death than one who does not[7].

The interaction and handover of patients between the ambulance and ED staff is critical to ensuring that patients receive the correct treatment in a timely fashion. ACEM members report that their interactions with ambulance services are professional and that paramedics provide high quality care within their scope of practice. However, ambulance ramping challenges the traditional 'respond, stabilise and transport' focus of ambulance services and raises an ethical dilemma for paramedics, who are effectively being asked to continue to provide ongoing emergency medical care for the patient beyond the scope and time frame of their expertise[8].

ACEM notes that ambulance ramping is a very visible problem, often referred to in the media and part of public discourse[9]. Importantly, ACEM also recognises this is not a new problem, with access block and ambulance ramping identified in numerous government consultations and audits in the past[10], with ACEM engaging and responding to these directly[11], seeking collaborative problem solving[12]

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[3] As at 2.
[4] As at 1.
[5] Australian Institute of Health and Welfare. Emergency Department care 2021-22 data. Canberra: AIHW 2023. Retrieved 2 October 2023
[6] As at 2
[7] Jones, P.G. and van der Werf, B. (2021), Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emergency Medicine Australasia, 33: 655-664.
[8] As at 1.
[9] Australian Broadcasting Corporation, 2023. *It's not safe: Figures show ramping is getting worse in Tasmania*. As broadcast on 28 July 2023; accessed on 2 October 2023.
[10] Crown in the Right of the State of Tasmania, May 2019. *Performance of Tasmania's four major hospitals in the delivery of Emergency Department services*. Tasmania Audit Office.
[11] Australasian College for Emergency Medicine, 2017. In-confidence *Submission to the Legislative Council Government Administration Committee A of the Tasmanian Government: Inquiry into the capacity of Tasmania's main hospitals to improve patient outcomes.*
[12] Australasian College for Emergency Medicine, 2019. *Statement on Access Solutions Meeting*. Media release published on 20 June 2019.

and calling for action by government to address continuing deterioration across the healthcare system[13].

For context, ACEM undertook two access block snapshot surveys across Australian EDs in 2019 (June and September) and presented them to the Health Minister at the time. Across both surveys, ED patients at Royal Hobart Hospital (RHH) and Launceston General Hospital (LGH) accounted for 29 per cent of those identified as access blocked at Australian hospitals. This was despite patients in these EDs making up less than 2 per cent of all ED patients at the time of the survey, representing the worst access block in Australia.[14]

Almost five years later, the situation has not improved, with wait times blowing out to levels previously never imagined possible. In 2021-22, it took over 22 hours for most (90 per cent) admitted patients to depart Tasmanian EDs (in comparison, the national average was just over 15 hours).[15] ACEM's 2022 *State of Emergency* report has also outlined alarming numbers behind the crisis in the acute health system. The report provided careful analysis of data gathered across each of Australia's states and territories. In the Tasmanian context, ACEM's data demonstrated the compounding pressures facing the state's EDs. Of note:

- There were 317 presentations per 1,000 population in 2020-21, the highest number ever recorded;
- 27 per cent of all presentations required hospital admission;
- It took more than 22 hours for most admitted patients (90 per cent) to depart the ED after arriving, with regional hospital ED patients waiting even longer (23 hours and 53 minutes).

ACEM acknowledges that while EDs across Australia are only one part of the broader healthcare system, ACEM's data indicates that efforts to date have not mitigated or improved patient experiences. In fact, the opposite has occurred.

ACEM Position

In very simple terms, to address ambulance ramping in the long term, government must concentrate on improving patient flow throughout the entire health system. The complexity of the issue means there is no one single measure that will "fix" the issues. This means looking outside the ED and ambulance realm and increasing investment in hospital and community-based services to ensure pathways *out* of the hospital system are enabling capacity within it.

Solutions must focus on improving capacity on hospital wards to meet community needs, and to increase investment in community-based care to provide for earlier discharge into primary care. Allowing for greater capacity within each part of the health system, and improving the way each part interacts as part of the patient journey, reduces strain on EDs. With less patients access blocked in EDs and waiting for in-patient beds, ED staff are freed up to accept incoming patients faster, including those arriving by ambulance. Ambulance staff, in turn, can transfer care of their patients faster and can return to the community for their next patient, reducing ambulance waiting times and improving public trust.

Achieving this outcome will require cultural change. ACEM acknowledges recent action to improve dialogue and engagement across the system through the Department of Health led Transfer of Care Working Group. As a collaborative initiative, the working group would be strengthened through the inclusion of emergency medicine physicians given their expertise. ACEM also contends that continued inaction to address the systemic challenges underpinning access block will restrict the ability of the Transfer of Care Working Group to achieve its aim - that is, to develop systems, and processes for

[13] Australasian College for Emergency Medicine, 2022. *Tasmania's emergency doctors: healthcare staff are breaking*. Media release published on 30 December 2022.
[14] Australasian College for Emergency Medicine, 2019. *Access block in Tasmanian EDs: Findings from the 2019 Access Block Snapshot Survey*. Report available upon request.
[15] Australian Institute of Health and Welfare. Emergency department care [Internet]. Canberra: Australian Institute of Health and Welfare, 2020 [cited 20 May 2021]. Available from: https://www.aihw.gov.au/reports-data/myhospitals/sectors/emergency-department-care.

mandated transfer of care of all ambulance patients within 60 minutes or less from arrival at the receiving hospital.

Solutions – Workforce

It is clear that one of the largest challenges facing the Tasmanian health system is the recruitment and retention of key medical and nursing staff. The College acknowledges workforce pressures and issues are being experienced in healthcare systems across Australia and Aotearoa New Zealand. The issues are particularly pronounced in Tasmania for reasons including: a lack of local, entry level opportunities in Tasmania; the size and distribution of the Tasmanian population; geographical influences on access to education and training; and a smaller overall workforce where even small movements such as retirement, leave or resignation can have a significant impact on the availability of a health profession and service.

Addressing workforce challenges is more than just looking at numbers of people in roles, it is about ensuring that the workforce is valued and treated with dignity. The current state of the workforce is that it is undervalued, overworked and the reservoirs of goodwill that helped steer the state through the worse of the COVID-19 pandemic are now largely depleted. Prior to COVID-19, Tasmania's population was ageing at a faster rate than the rest of Australia[16] leading to an increase in medical presentations, but also an increase in retirement from the workforce. COVID-19 hastened the retirement of some health practitioners, increasing the impacts of the pandemic on the Tasmanian health workforce.

This is particularly evident in the loss of senior medical and nursing staff from a range of specialities, including emergency medicine. The combined experience that has been lost will take at least a decade to replace, as more junior staff upskill, and remaining senior staff take on additional work and risk. The ageing and especially hyper-ageing of the Tasmanian population needs additional workforce considerations, and for the Tasmanian Government to provide initiatives in not only retaining the workforce but upskilling the workforce to be able to meet the needs of the hyper-ageing population.

Recommendation: The Tasmanian Government commits to growing the nursing and medical health workforce across specialities, and implements policies to retain experienced staff.

Solutions – System change

ACEM remains firmly committed to advocating for systemic action across the healthcare system. ACEM published the report *Access block: A review of potential solutions* in late 2022. Prepared by The Sax Institute, this report identified and outlined solutions that should be investigated and implemented to address access block.[17]

Specifically, the report called for the establishment of short-stay units, acute medical units and acute surgical units, where patients admitted via an ED can be accommodated, typically for up to 72 hours, while receiving appropriate multidisciplinary specialist management prior to discharge or transfer to a subspecialty in-patient service.

Further solutions were identified, such as outlining interventions to expedite patients' transition through the ED/in-patient service interface. Decisions as to the subspecialty in-patient service that is to accept an admitted patient are often complex and can only be resolved by negotiations between ED staff and in-patient teams or between different in-patient teams. This results in delays and can create significant tension. The interventions include recognition of the different imperatives of ED staff and in-patient teams, processes to promote mutual understanding and respect, and leadership that promotes communication and a favourable working environment which is not dominated by power differentials among healthcare professionals.

[16] Australian Bureau of Statistics. Snapshot of Tasmania. Canberra: ABS 2022. Retrieved 12 October 2023.
[17] Frommer M, Marjanovic S. Access block: A review of potential solutions. Sax Institute, 2022.

Recommendation: Work with ACEM to implement solutions outlined in the Access Block: A Review of Potential Solutions.

Solutions – Improving data

ACEM has developed 'Hospital Access Targets', a new access measure that describes three patient streams and sets distinct targets for those streams. Hospital Access Targets are intended to reflect the complexity of patient needs and the diverse pathways patients may take following attendance at emergency department. The maximum length of emergency department stay recommended by Hospital Access Targets for any one stream is 12 hours.

For patients needing to be admitted to hospital or transferred to another hospital:

- ≥60% should have an emergency department length of stay no greater than four (4) hours;
- ≥80% should have an emergency department length of stay no greater than six (6) hours;
- ≥90% should have an emergency department length of stay no greater than eight (8) hours; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours

For discharged patients:

- ≥80% should have an emergency department length of stay no greater than four (4) hours;
- ≥95% should have an emergency department length of stay no greater than eight (8) hours; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours.

For patients who need to be admitted to a short stay unit (SSU) for observation:

- ≥60% should have an emergency department length of stay no greater than four (4) hours upon SSU admission;
- ≥90% should have an emergency department length of stay no greater than eight (8) hours upon SSU admission; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours upon SSU admission.

Recommendation: Publicly report on ACEM's Hospital Access Targets.

Solutions – Hospital capacity

The inadequate capacity of the hospital system is a fundamental contributor to ambulance ramping. In-patient wards require sufficient staff and beds to meet the needs of our ageing and increasing populations. Too often hospital systems are being run near 100% ward occupancy rather than systems that encourage total ward occupancy closer to 85-90%. By working to capacity, the system cannot meet the needs of emergency presentations, which flows back down to the ED with the symptoms of long wait times, access block and ambulance ramping occurring.

It is increasingly clear that government investment in workforce and infrastructure is simply not keeping up with demand. Between 2011-12 and 2021-22 Tasmanian EDs recorded a 68 per cent increase of patients requiring hospital admission, an increase of over two times higher than the average of 32 per cent across Australia. Over the same period of time the number of available beds in Tasmanian public hospitals only increased by 33 per cent.[18] Addressing workforce shortages to reflect the growing demand is the key to ensuring people get the care they need in the most timely and safe way.

[18] Australian Institute of Health and Welfare. Hospital resource 2020-21: Australian hospital statistics. Canberra: Australian Institute of Health and Welfare, 2022 [cited 14 August 2023]. Available from: https://www.aihw.gov.au/reports-data/myhospitals/content/data-downloads

Capacity of hospitals and alternative care environments must be increased, including increasing the number of physical in-patient beds in public hospitals, extending in-patient and community services outside of normal business hours, increasing the size of the workforce to staff the additional beds and service capacity, and expanding models of hospital in the home. With all additional new services both in person and virtual care models, there needs to be increased staffing and space. Improved care in the community, for both primary care and tertiary services, will reduce reliance on the hospital system in the future and build a healthier population. An important focus of community-based services is residential aged care facilities, mental health care facilities, and specialist disability accommodation services.

Recommendation: Improve hospital in-patient capacity to ensure that it matches community need, with occupancy rate goals of 90% to allow for surge capacity.

Medical consultants are often the only people capable of admitting and discharging a patient. As their workload has increased, they often are unable to round on all their admitted patients each day. This means many patients are stuck in the ED waiting for a plan. If an in-patient team will not review admitted patients in the ED, the patient can go days waiting for a bed before they even get a plan from a specialist. While this is happening, beds and associated staff are kept occupied, limiting their availability to other patients, including those arriving by ambulance.

Significant improvements are required to discharge practices and pathways out of hospital. This means an investment in appropriate step-down services that allow people to be discharged into appropriately funded primary care services, which improves hospital capacity for those that require it. This may be particularly challenging in regional areas, but conversely may have a higher impact than in metro areas.

There is a need for dedicated discharge planners within the hospital system with appropriate social work, occupational therapy, physiotherapy, pharmacy and/or other allied health resources as necessary, and hospital executive backing to enforce medical and surgical AMO disposition planning on day one of admission. There should be resources put into patients being discharged to residential aged care facilities. Patient's wishes for future care should be considered, and clear guidelines for when/how to return to ED implemented.

Recommendation: Implement dedicated discharge planners (or similar) within the hospital system with hospital executive backing.

Solutions – Primary care capacity

While we acknowledge that the Tasmanian Government has limited ability to influence primary care capacity, nevertheless we must highlight the importance of reform in this area to achieve sustainable change. Access to appropriate primary care can prevent conditions from deteriorating to the point of requiring emergency care, yet the ability of General Practice to meet the needs of the population has been hamstrung by funding and structural issues for long periods, with the reduction in bulkbilling and gaps in primary care in some rural and regional areas of particular concern.

While recent investment in urgent care clinics is welcome, noting centres are operating in Hobart and Launceston, current evidence shows that the introduction of urgent care clinics in Australia has done little to reduce access block.[19] While urgent care clinics aim to support a cohort of patients who may otherwise present to an ED, these patients are not a main driver of ED pressure due to the unlikelihood of them requiring hospital admission. As access block is felt by patients awaiting an available in-patient bed, a greater focus is needed on pathways *out* of the ED to combat this.

[19] Australasian College for Emergency Medicine, 2023. *Position Statement: Impact of Urgent Care Centres on EDs in Australia*. Available from: https://acem.org.au/getmedia/f5179885-57e4-4a3c-966b-81bbdd28c9f2/S880-Position-Statement-on-the-Impact-of-Urgent-Care-Centres-on-EDs-in-Australia_1

Recommendation: Engage with and support Commonwealth Government-led process to reform primary care funding.

A short-term complication is that many GPs are maintaining the policy of not seeing anyone with infectious symptoms meaning a significant part of their workload is falling to the ED, as well as impacting ambulance call-outs. There are also situations where GPs will refer patients to the ED as it is a 'one-stop shop' for diagnostics which may be more convenient for the patient.

Lack of adequate support in the community for older patients leads to greater admissions to the hospital, typically via the ED and arriving by ambulance. Limited clinical oversight in aged care means increased and unnecessary ambulance presentations. Aged care placement needs are a daily issue. There are not enough aged care beds available to service the need. In-patients can spend considerable time waiting for placement (short or long term) and cannot step down from the acute care services and hence block acute beds.

Recommendation: Improve access to residential aged care facilities and provide support to elderly Australians to facilitate access.

There are similar issues relating to disability care. National Disability Insurance Scheme (NDIS) participants in hospital take an extraordinary length of time to be housed. Additionally, disability care with behavioural components can be very complex, leading to in-patient services refusing to take these patients, and significant ED lengths of stay as a result.

Recommendation: Provide additional staffing support to assist people with disability to access specialist disability accommodation in a timely manner.

Solutions – Response where ramping occurs

In addition to the systemic changes that are required, a whole of hospital response is required when ramping does occur, led by the executive and inclusive of all departments. EDs are currently held responsible for access block when the authority to resolve it lies elsewhere in the hospital. A cultural change is required to ensure that appropriate capacity is available to meeting community needs and that this must be driven with in-patient units.

Routine delays to ambulance offloading of over 30 minutes should trigger a systematic review of the hospital and ED. Any episode over 60 minutes should initiate an escalation policy and incident review, where emergency physicians have a responsibility to inform hospital management that patient care could be compromised, and hospital management has a responsibility to restore a safe working environment.

Recommendation: Implement measures to ensure accountability for addressing access block is shared across hospital departments

ACEM recommends a uniform approach to data definitions and capture for ambulance service and ED activities, as they relate to arrival and clinical handover of patients. ACEM also recommends using agreed KPIs across Australia and Aotearoa New Zealand for all patients, ambulance services and acute health systems. ACEM, ambulance services and health authorities should agree on uniform definitions, nomenclature and KPIs for ambulance delays.

This will ensure accurate measurement of ambulance service and ED performance. It will also ensure the efficacy of service improvement initiatives are accurately assessed and comparable, allowing better reproducibility and roll out of important initiatives.

ACEM suggests that the following KPIs be adopted:

- Within 15 minutes of arriving at an ED, 85% of patients should have their clinical handover completed.

- Within 20 minutes of arriving an ED, 95% of patients should have their clinical handover completed.
- Within 30 minutes of arriving an ED, 100% of patients should have their handover completed[20].

Recommendation: Implement consistent KPIs for ambulance to ED off-loading

Unsuitable Interventions

ACEM informs the Committee that best intended actions to address systemic pressures faced in the ED are not always effective in mitigating the impacts seen by access block. These include pre-ED interventions (for example, patient education, increases in community-based healthcare capacity and accessibility) or interventions within the ED (for example, increasing the size of the ED, process improvement programs and increasing the number of staff within the ED)[21].

Other solutions proposed by various governments, or stakeholders, that ACEM opposes includes:

Rapid Offload

ACEM does not support policies that allow for ambulances to leave a patient in a transition area when there is no capacity with the ED to care for that patient. There have been occasions in other jurisdictions where ambulance services have considered moving to rapid offload model of care, whereby patients are left at the ED door without any transfer. In that model, the ambulance staff cease to continue emergency medical care so that they are able to respond to other emergencies in the community.

Hospitals and EDs are already backlogged and staffed by a workforce that are already under excessive pressure. This means rapid offload is a highly dangerous response, which will lead to greater harm and fewer patients receiving the care they need in a timely fashion.
Emergency clinicians are concerned these approaches will soon lead to the return of "corridor medicine" as part of our daily expectations, that patients in the waiting room will effectively be ignored in preference to patients in an ambulance and that non-clinician executives will attempt to direct clinical care.

Holding Tents

Another highly problematic solution that has been attempted is to leave patients in tents at the entrance to the ED, staffed by nurses and paramedics. ACEM strongly opposes this approach as it does not address the causes of ambulance ramping and it compromises the quality provision of emergency care as they hold groups of undifferentiated patients with unknown acuity.

Rather than housing undifferentiated patients outside the hospital, a more constructive investment would be in transit lounges between the ED and in-patient wards. In this case the patients will be stable, their needs will be known, and they will have received initial emergency care.

Conclusion

ACEM reiterates our support for the Select Committee's review. ACEM members are dedicated to work collaboratively on sustainable outcomes, and we recall efforts seen in convening the June 2019 Access Solutions meeting as an example of goodwill to better support Tasmanian patients. Unfortunately, the intended systemic change stemming from that meeting has not been achieved and the reality across emergency departments is a deteriorating situation that continues to place Tasmanian patients at risk of adverse outcomes. ACEM requests ongoing engagement with the

[20] As at 1
[21] Frommer M, Marjanovic S. Access block: A review of potential solutions. Sax Institute, 2022.

Committee and to be included as part of any ‘next step’ outcomes that seek to improve patient care for all Tasmanians.

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Lee Moskwa, Manager, Policy and Advocacy (lee.moskwa@acem.org.au).

Yours sincerely,

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