Dear Ms Murphy- the Select Committee on Transfer of Care Delays (Ambulance Ramping).

Re: Select Committee on Transfer of Care Delays (Ambulance Ramping) Submission on the Terms of Reference.

Thank you for the invitation to provide a submission on the Terms of Reference for the Select Committee on Transfer of Care Delays (TCODs).

It is interesting to us as directors of Tasmania's largest hospital emergency department that we have simultaneously been asked to provide a submission to two concurrent reviews – this Select Committee, which seeks to examine the causes of transfer of care delays, and the *"Major Hospital Emergency Department Review to Improve Patient Access and Flow – Launceston General Hospital and Royal Hobart Hospital"*, seeking to improve flow of patients through the emergency departments.

The factors contributing to transfer of care delays and emergency department access and flow are inexorably linked. Essentially access and flow issues cause transfer of care delay. We encourage this Committee to liaise extensively with the Major Hospital Emergency Department Review group to ensure recommendations are system focussed and transferable across the health service. We would also note the Major Hospital Emergency Department Review is erroneous in title as this review is aimed at whole of hospital system response to access and flow. In short, this is not just an emergency department problem.

Emergency department staff know both why the emergency departments are dysfunctional and why TOCDs are on the increase. Both problems have the same cause – access block. Access block is the term used to describe the situation where a lack of access to inpatient hospital beds leads to patients spending excessive time in an emergency department. The Australasian College for Emergency Medicine defines 'access block' as: …'the situation where patients who have been admitted and need a hospital bed are delayed from leaving the emergency department (ED) for more than eight hours because of a lack of inpatient bed capacity.' Each access blocked patient in ED occupies space and resources that could be devoted to patients newly arriving by ambulance. When access block is severe, the ED cannot accommodate any more new patients and ambulance ramping occurs. TOCDs are just a symptom of access block. The term "patient flow" is in common usage within healthcare, unfortunately in Tasmania the inflow into the hospital system exceeds the outflow from the hospital system on a daily basis. The tank in between (hospital bed stock) is too small to accommodate the flow into the hospital, hence people remain in ED awaiting an inpatient hospital bed. This in turn fills the ED tank and prevents the ambulance service from transferring patients from their crews to an ED bed space under the care of the ED team. The outflow from the hospital bed stock (tank) is too small, this lack of flow out of the hospital further congests the ED and further contributes to TOCD. We fully accept there are efficiencies in processing within the ED and the hospital system, however there will be trivial improvement in TOCD if the Committee considers this just a hospital and ED processing issue rather than a hospital capacity and outflow issue.

In our ED, there are never more patients experiencing TOCD than there are patients experiencing access block. If we can fix access block the TCODs will also be fixed. The ED rebuild (slated for completion in 2026) will provide extra ED treatment spaces. Aggressive recruitment campaigns are needed to staff these areas. Recruitment to Tasmania hospital positions is difficult. The morale of the staff is severely damaged by chronic overcrowding and under-resourcing, a large component of the workforce wishes to only work part time due to the deleterious impact full time work in the hospital environment has. Whist the ED rebuild is sorely needed; a larger ED will not fix the TOCDs. If we

cannot get admitted inpatients to the ward the ED will fill up. Note the larger ED is required to deliver emergency care to expanding patient numbers in the future. Modelling has indicated we should expect 135,000 patients per year by 2035 we currently see approximately 80,000. The current footprint (completed in 2007) was designed to cater for 45,000/yr. which was exceeded in 2010 (only 3 years after opening). The new ED rebuild will increase treatment spaces from 61 (currently open) to 118 points of care (both lay down treatment spaces and chairs) however we already exceed 100 patients in the ED and short stay unit on a regular basis (including 30 patients waiting for inpatient beds).

Although access block is measured in and reported from EDs, it is not primarily an ED problem – it is a health system problem. Accordingly, this Select Committee, if it is to address the causes of TOCDs, must examine factors throughout the whole health system that directly contribute to access block. These factors include hospital bed stock, delays in accessing sub-acute beds, lack of NDIS community support (which traps people in the hospital system), lack of easily accessible community-based specialist clinics and follow-up processes. There are many other contributors not listed.

We thank you for the opportunity to be involved in finding a solution to TOCD and health system improvement for the Tasmanian public.

Regards

[redacted]

Dr Paul Scott
Act Dir RHH ED On behalf of the RHH Dir team.

In response to each Term:

a. *the causes of transfer of care delays, acknowledging Federal and State responsibilities;*

The Australasian College for Emergency Medicine (ACEM) released a position statement on "Ambulance Ramping and Diversion in November 2022" which concisely summarises the causes of transfer of care delays (TOCDs).

The statement highlights that **the most common cause for TOCDs is hospital access block**, where patients who have been admitted in ED and need a hospital bed are delayed from leaving the ED because of a lack of inpatient bed capacity, also known as **Access Block**. The result of this access block is TOCDs or in colloquial speak 'ramping.'

A main contributor of access block in Tasmania includes the lack of subacute care beds which are both state (district hospitals) and federally (residential aged care facilitates) funded. With the mean age in Tasmania growing increasing at an accelerated rate, the lack of access to residential aged care facilities will continue to increase the burden of Access Block and in turn, TOCDs. ACEM has a position statement on Access Block that highlights the *'whole-of-hospital'* and *'whole-of-system'* approach required.

Although there are other causes of TOCDs that will be provided to you from other parties through this submission process, their contribution to the overall delay is so low that mentioning them raises the strong possibility of distracting from the gravity that **access block** contributes to TOCDs. A prime example of this is the use of Urgent Care Centres (UCCs) to reduce presentations to EDs and therefore reduce access block – **this is simply not true** as outlined by an ACEM statement on UCCs noting that although there is some benefit to the community, the

impact of UCCs on Access Block and TOCDs is negligible as the patient population being served by UCCs are not the ones contributing to Access Block, i.e. the patient cohort who requires a hospital admission does not attend the UCCs. The UCCs address minor illnesses and injury with the patient destination almost entirely being home.

b. *the effect transfer of care delays has on:—*

(i) patient care and outcomes;

Multiple studies in the medical literature recognise that access block has a direct effect on mortality. Adverse patient outcomes and poor patient experiences are associated with ambulance ramping. Significantly, new patients presenting to an ED have a 10% greater chance of dying when more than 10% of patients waiting for admission are access blocked. In the RHH context that means patients are 10% more likely to die if we have 3 access blocked patients in ED. It is a rare day if we start below 20-28) patients who are accessed blocked. By extrapolation, the effect on mortality is obvious.

> *Jones, P. G, van der Werf, B. (2020). Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emerg Med Australas. 10. doi: 10.1111/1742-6723.13699.*

(ii) ambulance response times and availability;

There is good evidence to show that TOCDs also delay access to definitive assessment and care because of slowed ambulance response times, including clear evidence of increased 30-day rates of death. Anecdotally we have firsthand knowledge of paediatric cardiac arrest on the Tasman Bridge due to unavailability of an emergency ambulance (whilst multiple ambulances were only 2 kms away at the hospital unable to offload their patients).

> *Hammond, E., Shaban R.Z., Holzhauser, K., Crilly, J., Melton, M., Tippet, V., Fitzgerald, G.J., Eeles, D., Collier, J. & Finucane, J. (2012). An exploratory study to examine the phenomenon and practice of ambulance ramping at hospitals within Queensland Health Southern Districts and the Queensland Ambulance Service. Queensland Health & Griffith University: Brisbane*
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> *Hitchcock, M., Crilly, J., Gillespie, B., Chaboyer, W/, Tippett, V., & Lind J. (2010). The effects of ambulance ramping on Emergency Department length of stay and in-patient mortality. Australasian Emergency Nursing Journal: 13(1); 17-24*
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> *Dawson LP, Andrew E, Stephenson M, Nehme Z, Bloom J, Cox S, Anderson D, Lefkovits J, Taylor AJ, Kaye D, Smith K, Stub D. The influence of ambulance offload time on 30-day risks of death and re-presentation for patients with chest pain. Med J Aust. 2022 Sep 5;217(5):253-259. doi: 10.5694/mja2.51613. Epub 2022 Jun 23. PMID: 35738570; PMCID: PMC9545565.*

(iii) wellbeing of healthcare staff;

Wellbeing of staff is affected on multiple fronts including the significant moral injury of not being able to provide the optimal care for patients with the rate of attrition highest among emergency department workers at the Royal Hobart Hospital compared with other departments at the RHH. As a result, Tasmanian EDs are the highest utilisers of locum doctors who costing the state far more than contracted doctors would. This workforce is transient and do not retain corporate knowledge to enable increased efficiencies and standardised care in the medium to long term.

Multiple junior doctors rotating out of ED increase their FTE when on external rotations but reduce it again when they return to do battle in ED. We have had an enormous efflux of senior nursing staff and senior registrars. In their place we have extremely junior staff who bring with them increased supervision burden and increased risk. This lack of senior workforce means ED is unable to process patients as efficiently, this in turn contributes to TOCDs.

With the public having to wait longer due to access block leading to ED overcrowding, there is increased harm due to disgruntled patients as well as increased incidence of workplace health and safety incidents due to having to treat patients in inappropriate places. Violence to staff has become an unwelcome daily companion to ED staff. This further impacts staff retention with cumulative moral, psychological and physical injury resulting in senior staff leaving the workplace.

(iv) Emergency department and other hospital functions;

Although there are set limits of how many patients are allowed on each ward, this is no 'cap' for patients requiring care in the ED. Once all the ED beds are full, they overflow into the waiting room or remain with ambulance staff creating TOCDs. Waiting room patients are cared for by ED staff with unsafe nurse-to-patient ratios. Lack of privacy and a reduced ability to observe and care for patients impacts the quality of care the Tasmania public receive.

The lack of appropriate spaces to see patients leads to increased adverse events, longer hospital stays and increased morbidity and mortality.

The RHH is the only public hospital in Southern Tasmania. Clavary regularly shuts its ED on weekends and Hobart Private Hospital has greatly reduced hospital capacity over holiday periods. The RHH, cannot go on bypass (as occurs with mainland public hospitals), we simple absorb the increased attendances (both via ambulance and walk ins).

c. *the adequacy of the State Government's data collection and reporting for transfer of care delays;*

Firstly, it is important to understand that existing data systems interact poorly with each other. The Ambulance ESCAD system does not talk to ED Trak or Patient flow systems (e.g. Simon). Attempts to rectify this previously have failed as ambulance identifies by case number ED identify by patient details. These systems therefor cannot cleanly auto populate each other. The workaround is to have an ambulance hospital dashboard available to ED staff, but this is rarely referenced as triage and ED navigator staff need to look at a multitude of data inform systems (Trak, iPM, Med tasker, Simon). In addition, the hospital dashboard shows no clear input data, i.e. it does not indicate Ambulance arrivals by time (or category). In an ideal world the ambulance feed would:

- Talk to Trak and auto populate pre arrival information
- Display an arrivals/20 min display (i.e. we may get 5 sick patients from ambulance all at the same time and none for another hour), creating capacity to offload and start definitive treatment for these patient takes time because the ED is full almost all the time.
- If ambulance, ED and patient flow systems communicated well, a real time status would be visible to the integrated operations centre who allocate beds.
- Even more ambitiously we should use data which pre-empts arrivals not only on an hourly basis but over a multiday period. The Simon data systems are sophisticated enough now to predict ED attendances +/- <5% error for the next 48 hrs. We know our admission to hospital rate and our discharge from ED rate. We know our staffing roster gaps (noting it is harder to predict sick leave), we know our average length of stay per patient group, estimated discharge date and community hospital capacity. All of this can be amalgamated into a proactive rather than reactive system. This then can be acted on the day prior to the actual event. Elective surgery can be cancelled if necessary, staffing can be bolstered.
- I would also note Simon (used by patient flow) talks poorly to Trak. Beds are allocated on Simon but may not be available for 8-10 hrs) this then comes up as a bed available for an ED patient. This is not a real bed as it is not available for

hours. The Simon dashboard is not used in ED to any great extent but is heavily used by the patient flow team. The disconnected data systems result in failures or communication between ambulance, ED and integrated operations centre staff.

To make the data capture adequate:

- The systems need to talk to each other.
- We have become accustomed to extreme ED overcrowding and TCODs as the norm. Just this morning we heard in the hospital wide huddle "ED is looking pretty good." At that time, the ED had 25 admitted patients in 27 acute beds. Essentially leaving us 2 acute bed spaces to manage 220 patients who will arrive throughout the day (30+% needing admission). Despite this, the hospital managers at the huddle were celebrating because it was better than usual (e.g. 27-34 admitted patients, some of whom have 'slept' in the waiting room or on hard backed chairs in the clinic area). We therefore need to not normalise the extreme disfunction. This is not OK. Each time the ED has more than 8 in patients waiting for that 8 hrs for an inpatient bed this needs to be reported as a dysfunction measure. In addition, it needs to be acted on at a senior level to ensure there is adequate capacity to restore ED capacity and hence prevent TCODs.
- We need to have whole of system data capture and display (both at Department of Health, THS exec level but also visible to all staff). We can then adequately capture the hospital status, we can see what wards are doing things well, we can learn why some wards have improved systems and functions and we can learn from the high performing units and help the lower performers. This may help shed light on the barriers to performance: it may be a lack of infection control cleaners, or a surgeon operating all day so is unable to discharge a well patient home, or it may be cultural factors influencing ward staff behaviour.

d. *the State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures;*

There has been some State Government support for processes which facilitate rapid ambulance offload in times of severe demand. Unfortunately, the burden of this offload is usually absorbed by ED which is already under extreme pressure. More recently the THS has instigated rapid inpatient transfer protocols which forces the transfer admitted inpatients out of ED to the wards. Noting there remain strict inclusion criteria in the interest of patient safety. These patients end up in ward corridors or in rooms which have not been cleaned (whist the ward waits for a planned discharge). Ward staff have breaks postponed and supervision ratios increased. As you can imagine this is not popular amongst ward staff and does little to improve whole of system collaboration and performance. The sole purpose of this rapid inpatient transfer process is to get ambulances on the road so they can respond to time critical emergencies. We believe the ward staff still do not fully understand this premise.

This process is enacted approximately 3 times a week and has been active since January. In terms of efficacy, it does allow AT crews to get back on the road quickly. Staff in ED temporarily looks after these extra offloaded patients in a corridor whist they await the ward response to the process. The RIT process stays active until ambulance demand decreases (this may be as short as 1 hour or sometimes 10 hrs). On average activation of this process allows transfer of 8-10 ED patients out of ED to the ward at short notice. The impact however is that wards then still do not have capacity and hence no allocations or transfers occur for multiple hours after the process is stood down. In the meantime, ED fills up again, there is TOCD and the cycle repeats. The other much more concerning impact of preferential ambulance offload is that we are rapidly treating ambulance patients over and above the ED waiting room patients. These waiting room patients may also be having a heart attack but will not get a bed whilst we are offloading ambulance patients into the few available beds. We therefore have a

dichotomy of service where we are treating patients preferentially if they chose to call an ambulance and not a care system equally based on the urgency of patient care requirements.

We would also like the Committee to be aware of the separate Transfer of Care Working group comprised primarily by HACSU, AMNF AMA members and AT senior staff. This is chaired by Dale Webster. HACSU's position is that their members will not tolerate TOC >60/min by April/June 2024. Unfortunately, this group does not include hospital staff who are positioned to enact change. More disturbingly if AT offload their patients and make it EDs problem the trigger for ward assistance (rapid inpatient transfer) is no longer active. Hence ED will become even more dysfunctional. This process change will require redesign of triggers and subsequent education and cultural change from ward staff. This is an enormous amount of work if the 2024 deadline is to be met. Unfortunately, the correct people are not in the room regarding enacting this change.

e. *measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;*

As previously mentioned, there are many solutions that exist that claim to mitigate TOCDs. However, all of these have shown to have negligible impact to overall access block and only marginal improvements to flow. The fundamental issue of TOCDs is due to hospital access block. It has been shown that once the causes of access block are resolved, TOCDs will be reduced. Even hospital avoidance programs, which have been heralded as a solution to access block, have not been shown to be as effective as expected. The Committee should reference the ACEM State of Emergency Report which describes ED performance by State. Tasmania is the worst performing State in almost all metrics regarding access block. Access block is however a national problem. It appears multi-generational lack of health system planning has allowed most jurisdictions around Australia to cut back on acute hospital bed stock and not support proactive and efficient drainage into the sub-acute bed spaces (e.g. aged care and district hospitals).

Tasmania is still very much in the small-town mode. Many key hospital functions are an 8-5 Monday to Friday function. We have expensive operating theatres which run a day only list (other countries have 2 full OT theatre lists a day e.g. 0600-1500 and 1500 – 2400. This maximises utilisation of the resource and clears the elective list. Patients then do not end up in ED because of lengthy delays to OT worsening their chronic conditions and resulting in the need for Emergency care. Similarly, we have 6 medical teams Mon-Fri but only 1 on take over the weekend. Instead, we should properly staff and resource these units to be a 7 day a week service. These inpatient efficiencies will aid in increase bed turnover in the hospital and clear ED beds to enable TOC.

f. further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays; and

1. *Short Term*

Clear escalation policies for access block are necessary in the short term. Escalation policies that are prescriptive and based at the hospital level. To compliment escalation policies, performance targets need to be established for hospital capacity (e.g. level 3 or less for 80% of the period of reporting). Proactive data inputs anticipating ED and hospital load the day before it occurs to enable appropriate staffing and if needed rescheduling of elective theatre lists.

2. *Medium Term*

A cultural change to 7 day per week work week to allow hospital discharges on the weekend and investment in understanding the causes and impacts relating to access block

are important. We currently have a scatter gun approach to 'fix' access block without looking at the entire picture. Increased investment in Statewide workforce planning and proactive and efficient recruitment services is desperately needed. A healthier ED and hospital workforce will allow us to fully utilise hospital beds and ease access block, improving TOCDs.

3. *Long Term*

Investment in primary health is core to a healthy community that does not burden the acute health system. Solutions to reduce access block are also important, such as improving access to residential aged care facilities and subacute community-based support.

g. *Any other matter incidental thereto.*

Tasmania is in desperate need of an agency for clinical innovation. Other states such as Queensland, New South Wales and Victoria have state funded agencies for innovation (Queensland Excellence Commission, NSW Agency for Clinical Innovation and Safer Care Victoria). These agencies promote best practice, support high quality evidence-based care and fast track the discovery and implementation of innovative solutions in care, ensuring that healthcare systems are equipped to address evolving health challenges. Their work contributes to better health outcomes, increased efficiency, and the sustainability of healthcare services.