13 October 2023

The Secretary
House of Assembly Select Committee on Transfer of Care Delays (Ambulance Ramping)
Parliament of Tasmania
Parliament House
HOBART TAS 7000

Dear Select Committee on Transfer of Care Delays (ambulance ramping),

Re Submission: Inquiry into transfer of care delays (ambulance ramping)

The Australasian College of Paramedicine (the College) welcomes the opportunity to make a submission to the Inquiry into transfer of care delays (ambulance ramping) in Tasmania (TAS).

The College is the peak professional body representing and supporting paramedics across Australasia. We champion the role of paramedics in emergency, urgent and primary care, driving a connected, multidisciplinary approach to high-quality healthcare in all communities.

The College is future-focused and committed to enhancing person-centred care through sustainable, evidence-based approaches and holistic workforce initiatives that see paramedics valued and utilised across the healthcare system for their unique capabilities.

With our reach across jurisdictions, practice contexts and employment relationships, the College is uniquely and ideally situated to lead and advocate for the role of paramedics across the broader healthcare system.

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

Ambulance ramping, access block and emergency department (ED) delays could be isolated to an individual phenomenon, but often they are interrelated and always impact the patient negatively when prolonged. Ambulance ramping, also known as 'patient off stretcher time delay', 'transfer of care delay' or 'offload delay', refers to the time taken for patients unable to be transferred from the ambulance stretcher to the emergency department promptly.

The Australian Medical Association (AMA) reports that states and territories are falling short of their performance targets, and transfer times are increasing yearly.[1]

Multi-factorial causes include:

- EDs at capacity (all beds occupied)
- Multiple ambulances arriving at the ED simultaneously
- Mass casualty emergency event
- Lack of incentive to transfer patients off ambulance stretchers
- Centralisation of health care facilities and gradual reduction in the capacity of rural hospitals, necessitating ambulance transfers to more extensive, more capable health facilities
- All ambulance admissions from outlying hospitals occur through the ED

The diagram below highlights system factors that contribute to access block.

[1] Richardson B.D, Access block in Australia emergency departments 2017-2020. Available from https://doi.org/10.1111/1742-6723.13738 https://doi.org/10.1111/1742-6723.13738

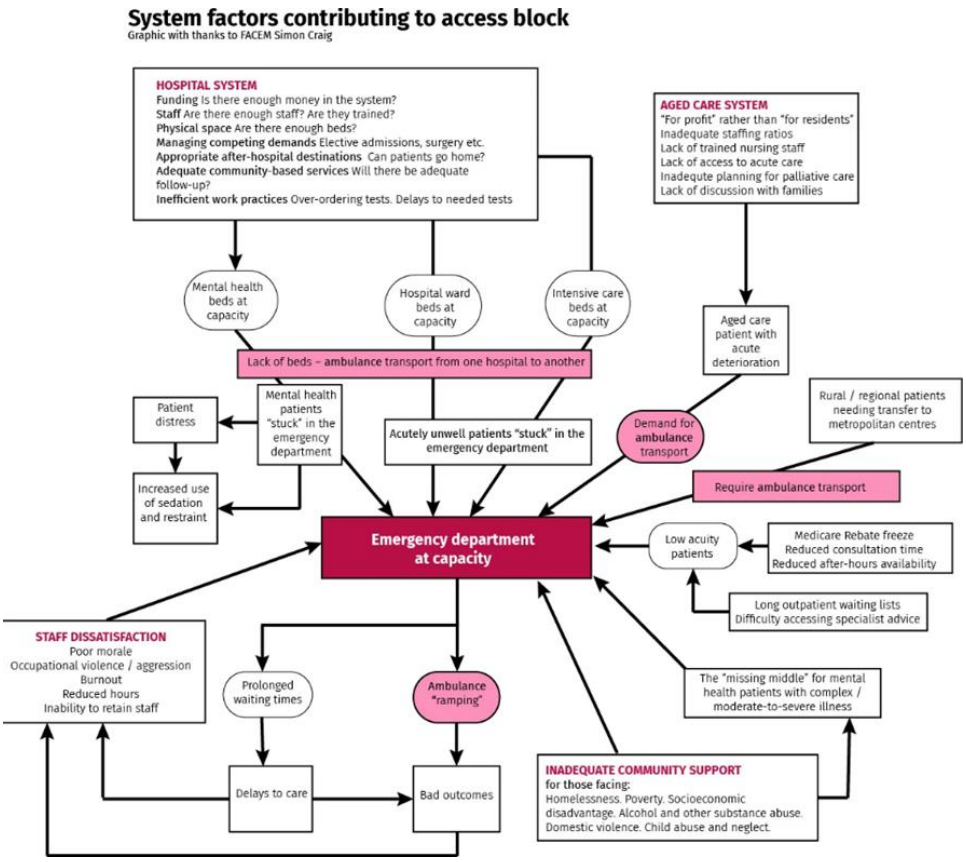

Diagram Credit to FACEM Simon Craig [Simon-Craig-diagram-re-draw-2.jpg (1254×1080) (acem.org.au)]

Access block refers to the situation where patients in the ED requiring inpatient care are unable to gain access to appropriate hospital beds within a reasonable time frame.[2,3] In September 2020, an average of 67 per cent of current patients waiting for admission were suffering access blocks across 93 Australian emergency departments.[4]

Multifactorial causes include:

- Hospital occupancy[5]
- Delays in discharge caused the inefficient flow in the discharge process
- Insufficient bed capacity[6]

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[2] Fatovich DM, Nagree Y, Sprivulis P. Access block causes emergency department overcrowding and ambulance diversion in Perth, Western Australia. Emerg Med J 2005;22:351–354

[3] Bein KJBR, Saartje, Ní Bhraonáin, Sinéad, Seimon, Radhika V, Dinh, Michael M. Does volume or occupancy influence emergency access block? A multivariate time series analysis from a single emergency department in Sydney, Australia during the COVID-19 pandemic. Emergency medicine Australasia. 2021;33(2):343-8.

[4] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.

[5] Bein KJBR, Saartje, Ní Bhraonáin, Sinéad, Seimon, Radhika V, Dinh, Michael M. Does volume or occupancy influence emergency access block? A multivariate time series analysis from a single emergency department in Sydney, Australia during the COVID-19 pandemic. Emergency medicine Australasia. 2021;33(2):343-8.

[6] INH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.

- Hospitals are impacted by the after-effects of the National Emergency Access Target (NEAT) initiative (NEAT stipulates that a pre-determined proportion of patients should be admitted, discharged, or transferred from Australian EDs within 4 hours of presentation), which resulted in a widespread and disproportionate increase in hospital admissions[7]
- Elective Surgery
- People who present to EDs with mental health issues are at greater risk of experiencing access blocks.[8]

The Australian Institution of Health and Welfare (AIHW) data indicates that in 2018-19, more than 522,500 ED patients suffered access blocks.[9,10] Between 2017-19, daily presentations rose by 11.4 per cent, and the number of patients who experienced access block increased by 46.1 per cent. Hospital admissions decreased to their lowest during the COVID-19 transmission peak but rose to pre-pandemic numbers by September 2020.[11] The number of patients experiencing access block at this time had increased to 67 per cent.[12] Presentation numbers have since exceeded pre-pandemic times, showing a rise in presentations of approximately 2.3% per year.[13]

The cost associated with inappropriate ED bed occupancy represents a significant cost to individual EDs and, consequently, to the overall healthcare system. According to an Australasian College for Emergency Medicine's (ACEM) internal analysis, this cost Australia's health system AUD$583 million (range of $222-833 million).[14]

Emergency Department Delays

ED delays refer to the patients presenting to the ED unable to get treatment promptly. There are recommended treatment target times related to the relative acuity of the nature of the patient's presentation, which is also associated with a funding model disincentive; urging staff to 'people push' than to proceed through the continuity of care.[15,16]

Multifactorial causes include:

- Reduction in primary health care services and limited extended hours available from General Practitioner (GP) services in the community, especially in regional areas[17]

[7] Silk K. The National Emergency Access Target: aiming for the target but what about the goal?: deeble institute; 2016.
[8] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.
[9] AIWH, Emergency department care, Emergency department care - Australian Institute of Health and Welfare (aihw.gov.au)
[10] AMA. Tasmania Online: AMA; 2022 [cited 2023 04/10]. Available from: https://www.ama.com.au/clear-the-hospital-logjam/phrc-tas.
[11] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.
[12] *IBID*
[13] AIHW. Emergency department care activity Online: AIHW; 2023 [Available from: https://www.aihw.gov.au/reports-data/myhospitals/hospital/h0714.
[14] https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block
[15] Scott IA. Public hospital bed crisis: too few or too misused? Australian Health Review 2009;34(3):317-24.
[16] Jones PG, Werf Bvd. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. Emergency Medicine Australasia. 2020;33(4):655-64.

[17] Crawford J, Cooper S, Cant R, DeSouza R. The impact of walk-in centres and GP co-operatives on emergency department presentations: A systematic review of the literature. International emergency nursing. 2017;34:p.36-42.

- Increases in ED presentations in Australia are driven by two broad patient groups: sick older adults and young adults with acute mental health problems[18,19]
- Difficulty staffing services; unbalanced physical and functional capacity for patients and ED staff.[20]

(b) the effect transfer of care delays has on:—

(i) patient care and outcomes;

Ambulance ramping impacts patients detrimentally. Patients are likely to face delays in assessment and treatment, increased risk of exposure to error, increased length of stay in the hospital, worse health outcomes and increased inpatient mortality.[21]

Recent research from Aotearoa New Zealand has shown that new patients presenting to an ED have a 10 per cent greater chance of dying within seven days of admission when experiencing delays in admission, while more than 10 per cent of current patients waiting for admission in that ED are suffering access blocks.[22] Additionally, up to three per cent of hospital bed days result from waiting for imaging, consults and other waits that could be reduced.[23]

(ii) ambulance response times and availability;

As of 2021-22, TAS has the third highest ambulance response time in Australia with a median time of 14.6 minutes.[24,25, 26]

Availability

- New ambulance stations are due to open in 2023, either completed or ongoing. There are currently 57 locations across Tasmania.[27]

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[18] DINH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.

[19] W. Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L, Bellolio F. Emergency department crowding: A systematic review of causes, consequences and solutions. PloS one. 2018;13(8):p.e0203316-e.

[20] O'Connor K, Golding M. Assessment of the availability and utility of the paramedic record in the emergency department. Emergency medicine Australasia. 2021;33(3):485-90.

[21] Access block, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block

[22] Werf. B. Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand

[23] Cameron PA, O'Reilly GM, Mitra B, Mitchell RD. Preparing for reopening: An emergency care perspective. Emergency medicine Australasia. 2021;33(6):1124-7.

[24] ABS. 4111 Ambulance Officers and Paramedics Online: ABS; 2022 [Available from: https://www.abs.gov.au/statistics/classifications/anzsco-australian-and-new-zealand-standard-classification-occupations/2022/browse-classification/4/41/411/4111.

[25] Health system dashboard [Internet]. Tasmanian Government. 2023 [cited 04/10/2023]. Available from: https://healthstats.dhhs.tas.gov.au/healthsystem.

[26] Tasmanian Government, Dept. of Health, Ambulance Tasmania. Operational Research in Health Report 2023. Available from: 11 Ambulance services - Report on Government Services 2023 - Productivity Commission (pc.gov.au)

[27] Government T, Health Do. Our Locations Online: Department of Health; 2022 [Available from: https://www.health.tas.gov.au/hospitals/ambulance/contacting-ambulance-tasmania/our-locations.

- Services are free for residents.[28]

- Health Transport Services (HTS) are available to transport non-emergency patients.

- Availability also affects people in the community as they don't have any emergency care available to them as the ambulances are ramped, posing a risk to people needing emergency medical treatment.

(iii) wellbeing of healthcare staff;

Impacts on paramedics:

Ambulance ramping and access blocks impact paramedics in several ways. Paramedics exposed to ramping identify many negative experiences (verbal abuse, physical abuse, compromised patient care, and patient fatality).[29] These negative experiences contribute to high depression, anxiety, stress, and post-traumatic stress disorder symptoms.[30] Ambulance response times in the community have deteriorated whilst ambulances are ramped at hospitals. This leads to worse health outcomes for those in the community with life-threatening emergencies waiting for an ambulance response, with more severe cases spending more time ramped before offload.[31]

The Senate Inquiry into mental health of first responders, 2019, made several recommendations to support mental health of first responders.[32]

Impacts on ED Staff:

Ambulance ramping and access blocks ramping lead to workload issues such as missed meal breaks, overtime, independent feelings of frustration and responsibility for the potential harm to patients waiting for care, which adds to the strained relationship with paramedics.[33] In 2019, access block and ED overcrowding were identified as the top workload stressors for ED staff.[34]

(iv) Emergency department and other hospital functions;

Ramping challenges ED systems of care and scopes of practice,[35] and are represented in health services when they are overwhelmed where 'patients receive sub-optimal care, including delays in assessment and treatment.'[36] Staff have an increased risk of exposure to error and pressure to meet four-hour turnover, which has led to symptom

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[28] Government T, Health Do. Ambulance costs if you live in Tasmania Online: Tasmanian Government Department of Health; 2021 [Available from: https://www.health.tas.gov.au/hospitals/ambulance/ambulance-costs/ambulance-costs-if-you-live-tasmania.

[29] Sullivan C, Staib A, Griffin B, Bell APA, Scott API, Hospital PA, et al. The Four Hour Rule: The National Emergency Access Target in Australia Online: Queensland Government; 2016.

[30] Phillips, W. J., Cocks, B. F., & Manthey, C. (2022). Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. https://doi.org/10.1037/tra0001241

[31] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022.

[32] Parliament of Australia Inquiry. (2019). The people behind 000: mental health of our first responders. [cited 13/10/2023] Available from: The people behind 000: mental health of our first responders – Parliament of Australia (aph.gov.au)

[33] Phillips WJ, Cocks BF, Manthey C. Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, & Policy. 2022;Publish ahead of print.

[34] ACEM. Access Block Online2022 [Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.

[35] Phillips WJ, Cocks BF, Manthey C. Ambulance ramping predicts poor mental health of paramedics. Psychological Trauma: Theory, Research, Practice, & Policy. 2022; Publish ahead of print.

[36] DINH MM, RUSSELL SB. Overcrowding kills: How COVID-19 could reshape emergency department patient flow in the new normal. Emergency Medicine Australasia. 2021;33:175-7.

treatment rather than core issue treatment. Longer offload times are associated with a greater risk of death and ambulance re-attendance within 30 days.[37]

Ambulance offload delays have caused substantial concern during the past decade in Australia. With offload times exceeding 17 minutes associated with increased the risk of death and reattendance,[38] which raises concern that Tasmanian ambulance offloading stands at 79.6 per cent within 30 minutes, a decrease from previous years.[39]

Startlingly, access block and ED overcrowding contributed to a 20 per cent to 30 per cent excess mortality rate every year in Australia, approximately 80 deaths per million population.[40] These numbers were calculated in 2009 to demonstrate the ability of the system to meet demand at the time. In the wake of COVID-19, our health systems are overwhelmed to utter distress.

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

- Data collection could be more efficient and shared more widely.

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

- increase availability of information on emergency departments and their alternatives
- Measures are useful to people looking but site is quite dry and difficult to navigate
- Improvements to secondary triage resources
- Training to triage operators

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

Access to after-hours primary health care contributes to patients visiting ED for non-urgent conditions.

The increased low acuity ED presentations (GP-type presentation), an aging population, and population growth contribute to the overall increase in ED presentations.[41]

The lack of understanding of what accurate GP-type ED presentation looks like – different understandings identified in the literature. This difference is more complicated for rural and remote areas with GP shortages.[42]

- Patients need consistent, ongoing care from a GP (continuity of care), but GPs are not appropriately funded, making ongoing care harder. "GPs are set up to fail by the system that is fragmented, rigid, and unsupportive."[43]

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[37] Ambulance ramping associated with 30-day risk of death [press release]. Online: The Medical Journal of Australia 2022.
[38] *IBID*
[39] AMA. Ambulance Ramping Report Card 2022. Online: AMA; 2022 2022.

[40] Fatovich DM, Hughes G, McCarthy SM. Access block: it's all about available beds. The Medical Journal of Australia. 2009;190(7):362-3.
[41] Yang B, Messom R. Association between potential primary care emergency service and general practitioner care utilisation in New South Wales. Emergency medicine Australasia. 2021;33(1):52-7.
[42] *IBID*
[43] Breadon P. General practices are struggling. Here are 5 lessons from overseas to reform the funding system Online: The Conversation; 2022 [Available from: https://theconversation-com.cdn.ampproject.org/c/s/theconversation.com/amp/general-practices-are-struggling-here-are-5-lessons-from-overseas-to-reform-the-funding-system-188902.

- GP services are predicted to outpace supply.[44]
- The ACT does not have ambulance ramping.

(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

The AIHW data from 2021-22 showed that the number of emergency presentations to hospitals has increased over the past four years in TAS, of which 10,976 presentations were categorised as non-urgent, and 66,135 semi-urgent.[45] Whilst the College acknowledges that many patients require assessment, diagnostics, and treatment in EDs, providing care to even a subset of these patients in the community through Urgent Care Centres, GPs, and multidisciplinary teams would deliver considerable savings to the TAS health system.

TAS has resources on the processes and effectiveness of secondary triage to divert patients away from hospitals.

The following alternative service delivery models highlighted below would meet the community's needs and address ramping, access block and emergency department delays:

- Community profiling program was undertaken across rural, regional and remote Tasmania to identify the paramedic needs of communities.
- Ensure the equitable distribution of paramedics at all levels, including extended care paramedics (ECP) and Intensive Care Paramedics (ICP) and update ambulance deployment modelling to reflect present-day demand, ensuring that ambulances are deployed as rostered.
- Explore innovative models of care utilising the skill sets of paramedics to better support communities that lack primary health care services, including consideration of embedding paramedics at facilities that do not have access to a doctor.

Recommendation 1:

Expanding Community Paramedicine (CP) / Extended Care Paramedic (ECP) to proactively combat the increased presentations of the aging population in the ED and transition back into the community.

The aging population consumes substantial hospital resources due to the lack of appropriate clinical care available in nursing homes and communities, further exacerbating the access block issue.[46] To address this, there need to be improvements to existing exit procedures; timely home care assessments, simplified and achievable disclosure agreements between the private and public services, and proactive interventions to identify potential at-risk patients.[47,48]

Aged care facilities must provide holistic care to deliver palliative and end-of-life care in the home or facility. With community paramedics as part of multidisciplinary teams with doctors and nurses, Australia's aging population can be treated and managed comfortably in the home/aged care facility, where the hospital could be a last resort or reserved for acute injuries before being released back to aged care. In 2020-21, inefficient hospital exit procedures cost approximately $197 million.[49]

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[44] Deloitte. General Practitioner workforce report 2022: Prepared for Cornerstone Health Pty Ltd May 2022. Online. 2022.

[45] AIHW. Tasmanian Health Service LHN Online: AIHW; 2023 [Available from: https://www.aihw.gov.au/reports-data/myhospitals/lhn/lhn604.

[46] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.

[47] *IBID*

[48] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.

[49] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.

Many profiling tools used to identify at-risk older Australians have standard features such as age, co-morbid conditions, and hospital presentation history.[50] Given the recent advancements in tracing technology and services in the past two years, there is an opportunity to refine existing tools to better track and intervene with these individuals. Significant reductions could be achieved by having in-home care that avoids ambulance transfers, ED presentations, and other risks to the patient, which could be reduced by having a single health care provider attend to the patient on-site.[51]

Within the first 90 days of aged care assessment, one in five older Australians had an unplanned hospitalisation or ED presentation.[52] The value of having a specially trained health care provider/professional to tend to these home cases and facilities would reduce the financial strain on hospitals to triage, assess, consult, treat, and refer/discharge patients presenting with non-urgent needs.

Providing patients with more options for multidisciplinary home care would steer them away from ED environments, which pose more significant substantial risks for older people, especially patients from residential care facilities.[53] Risks include deconditioning, delirium, hospital-acquired infections, pressure injuries and falls.[54] It is suggested that 13-40 per cent of all transfers from home care facilities to the ED could be avoidable by providing clinical care within these facilities and/or models.[55] [56]

Recommendation 2:

Expanding Extended Care Paramedics (ECP) programs further into rural areas

ECP programs work well in areas with significant referral networks, where synergy can be achieved between ECP attendance and access to other health care providers where continuity of care occurs for patients in the mid-long term. This has not been well extended into rural or remote areas, as these areas are often under different health care pressures, with similarly poor outcomes, but lack other support systems that would allow ECP to refer to other providers promptly.

Expansion of these models of care could support hospital initiatives and improve chronic health conditions' management. The benefits associated with paramedics working in primary care settings include a reduced GP workload, better access to health assessment and care for patients and career development within the health care system for this group of professionals. An example of this is in Aotearoa New Zealand, where St John has formalised the ECP role and ECPs are now able to support patients with urgent and unscheduled needs. Through ECPs, patients have access to a wider range of skills and medicines closer to home. This program boosts rural health service capacity, fills the workforce gap, and reduces the demand for EDs and ambulance services.

Paramedics have been increasingly established in primary care over the last decade in several countries. Paramedics are educated and experienced in providing emergency care, and low acuity health care to people in a variety of different settings. They regularly attend a wide variety of patient presentations, ranging from critical, and traumatic

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[50] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.
[51] Unit ARaR. Public hospitals: Cycle of crisis. Online: AMA; 2021.

[52] Inacio MC, Jorissen RN, Khadka J, Whitehead C, Maddison J, Bourke A, et al. Predictors of short-term hospitalization and emergency department presentations in aged care. Journal of the American Geriatrics Society. 2021;69(11):p. 3142-56.
[53] Gurung A, Rome M, Clark S, Hocking J, Dhollande S, Broadbent M. The enigma: Decision-making to transfer residents to the emergency department; communication and care delivery between emergency department staff and residential aged care facilities' nurses. Australasian Journal on Ageing. 2022;00:1-8.
[54] *IBID*
[55] *IBID*

injury to chronic, complex medical syndromes in aged care facilities, mental health illness, substance use disorders, and palliative and end-of-life care.

TAS Health Department should consider the wider implementation of ECPs practice across the state, both as part of and separate from the TAS Ambulance Service, to play a vital role as part of the health workforce in multidisciplinary teams alongside GPs, nurses, and allied health professionals as an initiative and action to address the impact of ambulance ramping, access block and emergency department.

As well, significant investment in Ambulance Tasmania to increase their support staff, as well as frontline staff, would enable a more robust health service.

Recommendation 3:

Introduce the role of Chief Paramedic Officer (CPO) within the senior health officer roles to engage and better utilise the paramedic workforce.

The College strongly supports appointing a CPO for TAS. A CPO would add value when governments make critical decisions impacting their communities' health care.

Like other senior officers in health roles (such as Chief Health and/or Medical Officer, Chief Nursing and Midwifery Officer, etc.), the role of the CPO should be included as part of the clinical leadership team for health. The function should sit in a suitable governmental entity outside of jurisdictional ambulance services to fully encompass and represent all paramedics working across various health settings.

The role is critical to ensure that complex problems facing health systems can be addressed with a co-designed, multidisciplinary, interprofessional approach. A CPO would enable the TAS government to have an expert paramedic available to advise how paramedics could contribute to existing health systems through their unique clinical skill set and help to address some of the health workforce challenges seen across the health system, particularly around the metropolitan, rural, remote divide.

(g) Any other matter incidental thereto.