INQUIRY INTO IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

Organisation: Royal Australian and New Zealand College of Psychiatrists

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Inquiry into the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Improving the mental health of the community

Introduction

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists welcomes the opportunity to respond to this inquiry regarding the impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college, has strong ties with associations in the Asia and Pacific region. The College has over 7700 members, including more than 5500 qualified psychiatrists (consisting of both Fellows and Affiliates of the College) and over 2100 members who are training to qualify as psychiatrists (referred to as Associate members or trainees).

The NSW Branch represents nearly 1950 members, including some 1350 qualified psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

People with mental health conditions and emergency departments

Before addressing the terms of reference, we wish to state from the outset that, in our view, ambulance ramping reflects an entire health care system operating at its limits, a system facing constant under-investment in critical areas of care, including in the community setting, and a system characterised by inadequate planning and piecemeal approaches to reforms.

Our members, working in emergency departments, report that patients presenting to emergency departments for mental health care routinely experience excessive waits often in inappropriate, and at times unsafe environments. Many have underlying trauma and present to ED because they have nowhere else to go. Our members report that it is a constant challenge for emergency department staff to find a safe path for patients such as admission to an inpatient bed, or home with appropriate community supports in place. These dangerous delays and negative experiences are an indicator of widespread system problems across acute psychiatric and community-based mental health care, and are harmful to people who need care and stressful for staff and carers providing this care.

About our submission

In preparing our submission, the Branch consulted with psychiatrists who have extensive knowledge of and experience in the delivery of mental health services in emergency settings.

As part of our submission, we have included a spreadsheet containing the latest (2021) AIHW (Australian Institute of Health and Welfare) *Data on Mental Health Services Provided in Emergency Departments.* In various 'Tabs' we have highlighted important and relevant data for the Committee to consider as part of their deliberations.

(A) The causes of ambulance ramping, access block and emergency department delays

In consultation with our members, several factors were suggested to cause ambulance ramping and access block. These include:

Lack of inpatient beds for admitted ED patients

One of the main reasons access block and ambulance ramping occurs is that there are simply not enough beds in our hospitals to deal with situations when EDs experience surges in patient volumes or when bed occupancy rates are sustained at peak levels (90% and above) for long periods of time. The lack of availability of inpatient beds leads to the boarding of patients in the ED, which in turn, blocks access to clinical and emergency care for newly arriving patients experiencing an emergency.

As reported by our members and reflected in the data (see Tab ED.18), such surges happen after hours, late at night and on weekends, and are exacerbated because people are unable to access primary health care such as their general practitioner (GP) at those times.

Our members also reported that poor planning and lack of regard to demographic changes (e.g., ageing population) have also contributed to the current challenges with access to emergency medicine. To some extent this is borne out in data linking hospital bed numbers and ED presentations. As shown in the table below, growth rates in ED presentations have outstripped the rate of increase in hospital bed numbers in the period 2014/15-2018/19 by a factor of three to one. It is important to note that NSW's (public) hospital bed numbers of 2.78 per 1000 population) is below the OECD average of 4.7 per 1,000 population [1]. This may explain the capacity constraints members and other stakeholders voice concerns about when advocating for improvements to our hospital system.

Public hospital bed numbers v ED presentations 2014/15-2018/19							
Year	2014–15	2015–16	2016–17	2017–18	2018–19	Change over 5 years	Ave change %
Hospital beds[2]	20,242	21,018	21,152	21,147	21,253	5%	1%
ED presentations[3]	2,538,402	2,637,735	2,723,189	2,817,884	2,920,777	15%	3%

Workforce shortages

We heard reports from members that psychiatry workforce shortages are particularly pronounced in specific settings (inpatient units and emergency departments) and sub-specialties (addiction psychiatry and child and adolescent psychiatry). We heard, for example, that Nepean Hospital has nine psychiatry consultant positions vacant at present and another 10 short-term (3 month) Visiting Medical Officer (VMO) contracts that are regularly renewed at the last minute because of workforce shortages and problems attracting specialists to newly created roles. This is impacting on service delivery to an extremely vulnerable group and contributing to overcrowding in ED and access block.

Our members also reported concern about the declining GP workforce and its impact on EDs particularly in relation to the management of people with chronic complex mental health conditions. GPs are best placed to provide appropriate, tailored, affordable and long-term mental health care for their patients, and more needs to be done by government, to address GP workforce shortages, including remunerating GPs properly for providing care to people with chronic mental health conditions. The NSW population should have equitable access to GPs, and access needs to be affordable.

Increased complexity and acuity of patients

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[1] Australian Institute of Health and Welfare). Hospital Resources 2015–16: Australian Hospital Statistics Canberra

[2] Australian Institute of Health and Welfare - Hospital Resources 2017–18: Australian hospital statistics Canberra

[3] NSW HealthStat Emergency department presentations. Accessed 17 August 2022, available at https://www.healthstats.nsw.gov.au/#/indicator?name=-unplanned-ed&location=NSW&view=Trend&measure=DSTRate&groups=Sex&compare=Sex&filter=Sex,Persons

As the population ages, a growing number of patients with chronic conditions, including mental illness, require emergency services. These patients with increased complications or with several comorbid conditions, including trauma, often require lengthy and complex assessments that utilise advanced diagnostic technologies to determine their need for hospital admissions or further treatments. We are also seeing similar trends with increasing numbers of young people presenting to ED with complex mental health conditions including suicide distress or self-harm.

Another factor reported by members as contributing to the demand for mental health services, and the higher acuity and complexity of consumers' needs, is our society's changing patterns of alcohol and drug use, especially methamphetamine use which has seen a 13-fold increase in ED presentations in the past 10 years [4].

Finally, the research base for the treatment of people with complex mental health conditions who are in crisis is grossly inadequate. This is likely to cause confusion, treatment delays, and a lack of standardisation of interventions.

Inadequate community mental health services

Another major factor contributing to access block (and therefore ambulance ramping) is the lack of appropriate community-based services for people with mental health conditions. Our members reported that many people with mental health issues find it challenging to access community-based care when and where they need it (e.g., outside hours), and consequently, turn to EDs for care and treatment. Mostly, this would involve arriving by ambulance (see Tab ED.2).

We heard that when they go to an ED, they spend more time there than people without a mental health issue, and if admitted, can face unnecessary lengthy stays in ED because of a lack of step-up and step-down facilities and supported living and collaborative care services in the community. Part of this challenge is that psychiatric assessments naturally take time, as they require a full psycho-social assessment and gathering of collateral information, as well as consideration of the Mental Health Act's requirement to maintain autonomy where possible before safe disposition decisions can be made. An obvious solution to this problem is to expand community mental health services to ensure people with mental health conditions can get the care they need *prior* to escalating into a crisis, and in the process, reduce their reliance on an already strained emergency and hospital system.

(B) The effects that ambulance ramping, and access block has on the ability and capacity of emergency departments to perform their function

As noted earlier, ambulance ramping, and access block can lead to the 'boarding' of patients whereby they are made to wait lengthy periods of times in inappropriate locations. Our members reported that this can have damaging effects not only for people with severe mental health conditions, but anyone presenting with serious health issues. Our members reported that it can delay and dilute the quality of care, potentially increasing a patient's risk of further harm (even death) after leaving the ED. Members also reported it can place ED staff at risk if patients are not attended to in a timely manner. It can also lead to staff 'burning out' and leaving the ED workforce altogether, adding to the current workforce shortage problem experienced across the sector.

Our members expressed concern that EDs, in their current configuration, are not a suitable place for the growing mix patients who have severe mental health conditions, alcohol, and

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[4] NSW HealthStats - Methamphetamine-related hospitalisations. Accessed 18 August 2022, available at https://www.healthstats.nsw.gov.au/#/indicator?name=-beh-drug-meth-hos&location=NSW&view=Trend&measure=Number&groups=

other drug issues, ageing related illnesses such as dementia, etc., and speculated about how EDs may be redesigned to fit the mental health needs of all presenting patients.

(C) The impact that access to GPs and primary health care services has on emergency department presentations and delays

There has been growing discussion around whether some patients presenting to ED should have been treated by their primary health care provider such as their GP. While there is merit to this argument, the reality is that access to such providers is getting more and more difficult. Members report lack of appointment availability, high cost (e.g., fewer GPs bulkbilling), lack of after-hours access, and the perception these services are unable to deal with urgent and complex problems, as some of the reasons patients choose to go to ED instead of a primary health care provider. Members also reported that lack of access to private psychiatry leaves GPs with no option but to send their patients to ED for psychiatric assessment.

Members noted that GPs have an important role to play in managing people with complex health issues and reducing demand for low acuity ED presentations. But they need to be properly resourced with and have access to additional help, such as, nurses and allied health (e.g., psychologists) who work together providing comprehensive patient-centred health services. Various iterations of these services have existed (e.g., Medicare locals) but they have tended not to be integrated with medical specialists or funded properly. Primary health care providers also need to be properly remunerated for this work and they need to be consulted to determine which services are needed and funded.

Our members report that evidence-based models care (e.g. Safe Haven) [5] need to be developed that measurably improve the experience and outcomes of people who need acute mental health care. These models should be developed in consultation with key stakeholders, particularly people living with mental health conditions and their advocates.

(D) The impact that availability and access to aged care and disability services has on emergency department presentations and delays

Older people living in residential aged care facilities (RACF) often have significant and complex health issues. They are more likely than people who reside in the community to become acutely unwell, present to EDs and require admission to hospital. According to the Australian College of Emergency Medicine (ACEM), older people in RACF represent an estimated 30 transfers to EDs per 100 beds per year and are more likely to experience access block than older people living in the community [6].

We are not aware of any data showing level of ED presentation by disability type. We would recommend that the Committee consider the feasibility of NSW Health collecting this data in the future to enable stakeholders and policymakers to better understand people with disability's access to and experience of EDs.

Our members noted discharge from the ED or wards back to the RACF could be significantly improved for both older people and people with disability, particularly in relation to clinical handover and access to NDIS and Aged-Care packages.

(E) How ambulance ramping and access block impacts on patients, paramedics, emergency department and other hospital staff

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[5] Safe Haven is a friendly, compassionate, and safe place to visit if you or your friends, family or carers, have been experiencing emotional distress, including suicidal distress and you would like some support and social connection. Most of the staff have their own lived experience of suicidal distress and can listen, understand, and offer support.
[6] ACEM Submission to the Royal Commission into Aged Care Quality and Safety September 2019

Our members report ED lengths of stay and wait times for admission to an inpatient bed are disproportionately longer for mental health patients compared to patients presenting with other conditions. The long waits for mental health patients are associated with several negative safety and clinical outcomes including increased risk of death, self-harm, violence and aggression in the ED.

They say prolonged waiting for care causes patients to become frustrated and dissatisfied and results in an increased number of patients who leave without being seen by a medical specialist. This puts patients at risk of a serious adverse outcome and can put their carer at serious risk of harm if patient's condition deteriorates and becomes unmanageable.

We heard from our members that the ED work environment increases the risks of bullying and fatigue among staff, which adds to the challenges in recruiting and retaining staff. The risk of staff leaving increases, because the working conditions are intolerable and a threat to their own mental health. In this high-stress environment it is not uncommon for health care workers to experience vicarious trauma (exposure to traumatic events) and the effects of moral injury (behaviours that go against a person's values and moral beliefs). Members also reported that the demands of managing complex patient and family relationships in an already highly stressful environment can further exacerbate patients' symptoms and make them harder to treat.

(F) The effectiveness of current measures being undertaken by NSW Health to address ambulance ramping, access block and emergency department delays

Our members reported the Matrix system, which ambulances use to determine the closest and most clinically appropriate ED to transport patients to, can result in EDs receiving large numbers of out-of-area patients, adding to access block and ambulance ramping. The problem when patients are taken to an out-of-area ED is that their local mental health team is not on hand to provide the information needed for timely treatment. Further, because electronic medical records are not accessible across local health districts, clinicians are required to spend time taking a medical history instead of acting on information that is readily available but not easily accessible. We submit that the Matrix system to allocate patients warrants further investigation to determine if it is operating effectively.

Recommendations

The NSW Branch submits there is an urgent need for additional investment across the entire healthcare system, including inpatient and community care, to relieve pressures currently being experienced in EDs and to ensure people with mental health (and other emergency) conditions get the best care in a timely manner and close to where they live. With this in mind, we recommend the Committee call on the government to:

1. Invest in additional resources to increase inpatient mental health beds and non-hospital alternatives, such as step-up/step-down services, short stay units, hospital in the home, and telehealth

2. Invest in the expansion of community-based mental health care, including after-hours mental health crisis care outside the ED. This includes prioritising community-based care that is responsive to acute need in children, adolescents and adults, and older people such as existing 'core' community health teams (Acute Care Teams and Case Management Teams).

3. Take immediate action to address the shortfall of child and adolescent psychiatrists in our hospitals

4. Ensure sufficient psychiatry sub-specialist staffing within EDs, including psychiatrists, psychiatry registrars, and senior nursing staff

5. Ensure services that respond to homelessness, family violence and drug and alcohol are available to patients and their ED clinician when required, to reduce the occurrence of repeat presentations. This includes improving access to specialist community supports, such as allied health professionals who can provide early intervention to prevent issues escalating to a crisis.

6. Review the Matrix, the system ambulances use to determine the closest ED to transport patients, to establish the extent to which it contributes to ambulance ramping and access block

7. Facilitate data linkage between jurisdictional hospital clinical data systems to enable immediate access to patient electronic records

8. Prioritise funding for research into effective treatments for people who are in crisis

9. Request NSW Health to consider collecting data on disability type to better understand people with disability's level and type of access to ED.