Submission No 24

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

Organisation: South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs

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To The Hon. Greg Donnelly MLC & Members of Portfolio Committee No. 2,

On behalf of the South Western Sydney Local Health District - Medical Staff Council (SWSLHD-MSC) Chairs, we provide this response to the call for submissions to the '*Parliamentary Inquiry into the Impact of Ambulance Ramping and Access Block on the operation of Emergency Departments across New South Wales'*. This letter summarises the collective opinions of the 1,500 senior medical staff appointed to the hospitals of SWSLHD including Campbelltown & Camden, Liverpool, Fairfield, Bowral and Bankstown Hospitals which will collectively manage approximately 300,000 Emergency Department (ED) presentations this year; receive over 80,000 ambulance transfers in to their EDs and admit over 80,000 patients to inpatient wards[1]. The SWSLHD-MSC is strongly committed to calling for improvement in the care of patients requiring acute care in our public hospital system and support for the nursing, medical and allied health clinicians striving to maintain safety and quality of care.

The inability to release our ambulance officer colleagues and their vehicles back into the community we refer to as 'ramping' and the inability to transfer in a timely manner acutely ill patients in our EDs requiring inpatient hospital admission to ward beds we refer to as 'access block' are problems that have existed over many decades despite the best intentions and efforts of hospital staff to improve efficiency within our hospitals. Access block is inversely reflected by a Tier 1 key performance indicator (KPI) measuring the percentage of admitted patients transferred out of the ED in less than four hours known as the Emergency Treatment Performance (ETP) (*See Figure 1.).* Ambulance ramping is inversely reflected by the Tier 1 KPI measuring the percentage of ambulances arriving in EDs to being able to offload their patients within 30 minutes known as Transfer Of Care (TOC) (*See Figure 2.).*

Figure 1. Emergency Treatment Performance for SWSLHD Facilities - July 2021 to June 2022

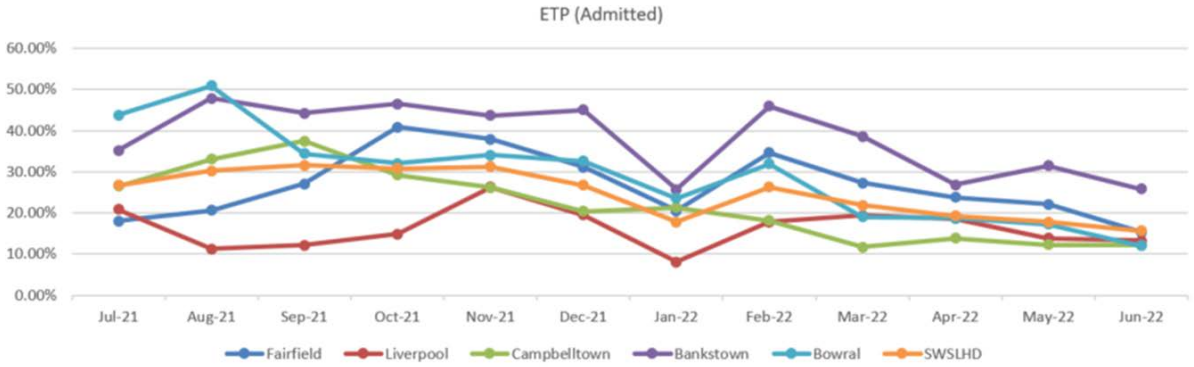
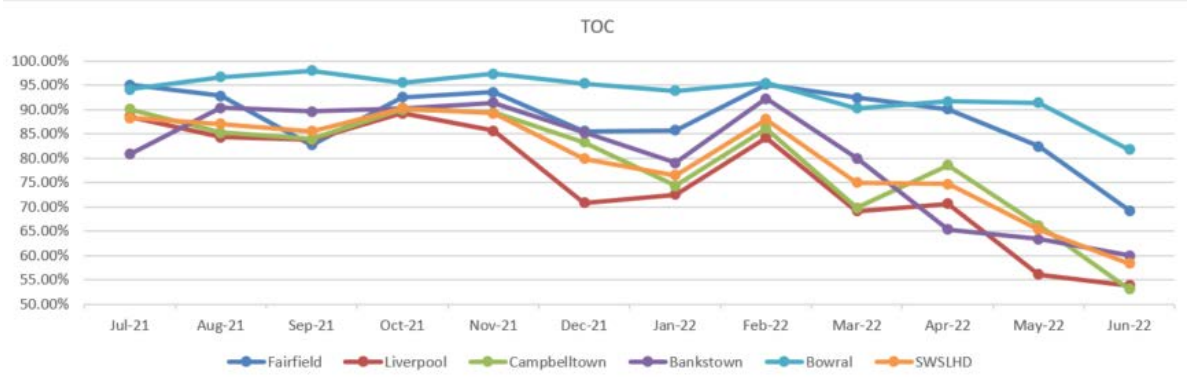


Figure 2. Transfer Of Care Performance for SWSLHD Facilities – July 2021 to June 2022



The rapid population growth in SWSLHD over the last decade has quickly overtaken the capacity of our hospitals and despite being acknowledged in *'Report No. 55 Current and Future Provision of Health Services in South-West Sydney Growth Region'*, the opinion of the SWSLHD-MSC is that South Western Sydney's hospitals remain very much under-resourced.

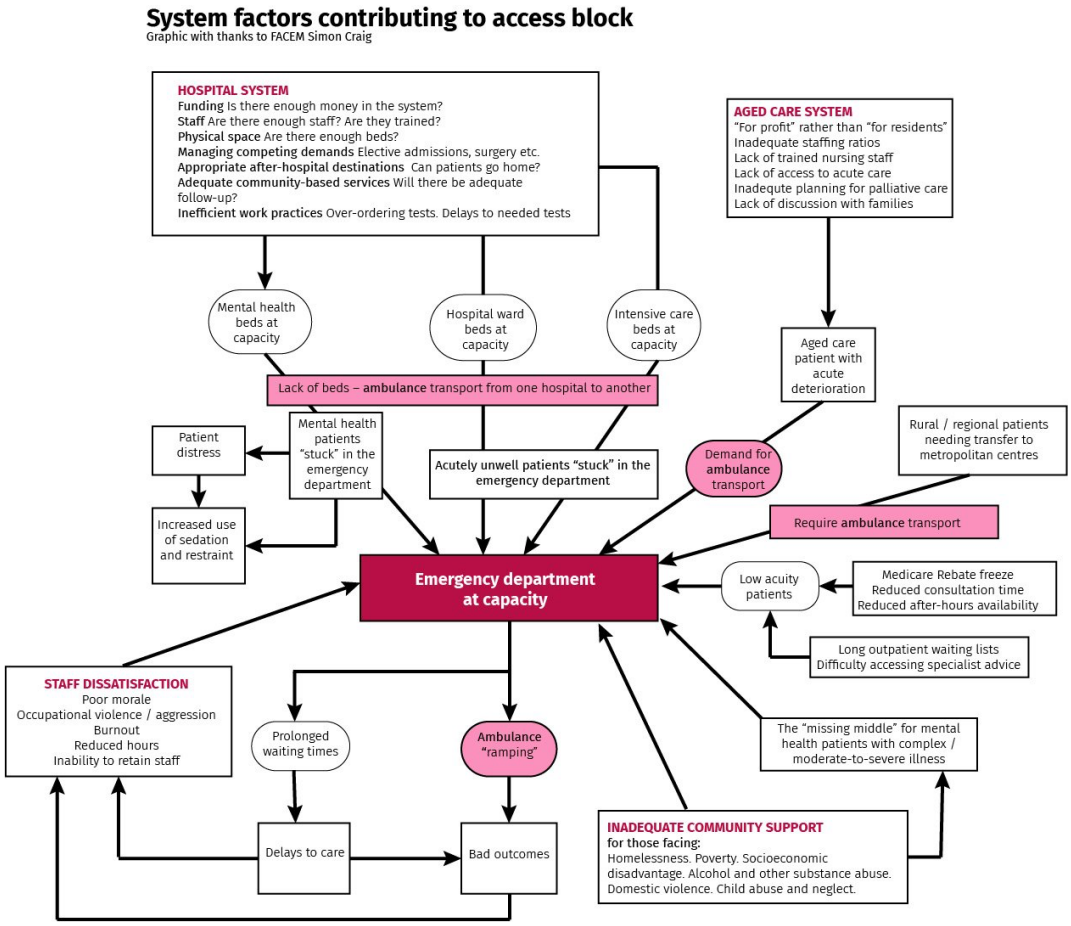
The intertwined issues of ambulance ramping and ED access block in South Western Sydney is a reflection of the under-resourcing of health services both within the public hospital system and in the community. Patients have had to over rely on hospital-based services to obtain 'non-urgent but necessary care' due to the relative paucity of community-based options and resources available to them. Additionally, this issue in SWSLHD is magnified by a large proportion of families being of culturally and linguistically diverse (CALD) backgrounds challenged by the scarcity of interpreter health services in the community, the private health sector and Commonwealth facilities. Moreover, with lower rates of health literacy and a relatively higher proportion of families belonging to lower socioeconomic and disadvantaged groups, fewer access private health options or services requiring gap payments.

The SWSLHD-MSC's responses to each of the Terms of References are listed on subsequent pages:

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

Figure 3. below depicts the multiple system contributors to access block common to most EDs across NSW.

Figure 3. System Factors Contributing to Access Block – Australasian College of Emergency Medicine (ACEM)



In SWSLHD, the SWSLHD-MSC feels by far the largest contributor to ambulance ramping, access block and emergency department delays is the lack of permanently funded inpatient beds with SWSLHD hospitals constantly at or over 95% occupancy. The operationally healthy 80% occupancy rate still allowing capacity for ED accessible beds is now a distant memory as at the beginning of the COVID-19 pandemic this buffer was necessarily sequestered for COVID-19 hospitalised patients thereby forcing operations considered business as usual (BAU) to operate with a significantly reduced bed base. Demand for beds now is even greater than levels pre-COVID-19 due to the need to alleviate the long surgical waitlists incurred during pauses to elective surgery during the pandemic.

Constant congestion of hospital inpatient beds has resulted in obstruction to the flow of patients through the system and backlogging of admitted patients waiting for transfer into inpatient beds. Many of late have needed to remain for long periods in our EDs; some for days. It is this problem, rather than just the volume of increasing

presentations alone that has led to the inability for ambulances to offload their patients into ED treatment spaces frequently causing them to 'ramp'.

Increasing demand for acute hospital care has occurred due to the rapid population growth through families migrating from other parts of the city to the South Western Sydney Corridor; attracted by affordable housing and influenced by the sharp rise in interest rates and costs of living.

Affordable private specialist care for 'Chronic & Complex' medical patients is relatively lacking in the South West in comparison to other more affluent areas of Sydney. Without specialist level care for many of these fragile chronic conditions, destabilisation invariably occurs, and many are forced to attend EDs to be admitted under public hospital specialist teams for correction to their health trajectory to be able to return safely back into the community. Currently, there is very little public hospital provision for this type of maintenance care as acute and critical care activities currently consume the bulk of the hospital's resources.

In addition, the difficulty in South Western Sydney to recruit and retain a skilled workforce at of disciplines and levels, those left behind are forced to work with fewer supports and higher workloads in comparison to some of their colleagues working in other LHDs. Some SWSLHD EDs are at the mercy of locum medical officer staffing often resulting in undermanned EDs; particularly after-hours during peak presentation periods. Fewer permanent doctors and higher, still-uncapped patient to nursing staff ratios invariably result in longer wait times and slower processing times for most SWSLHD ED patients.

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

The primary functions of our EDs are firstly to resuscitate the critically ill patients arriving to the hospital from the community and secondly for those who are yet to be critically ill, to be assessed, risk-stratified and to receive commencement of their initial management prior to their disposition and further needs within the overall health care system being determined. As of late in SWSLHD, high levels of access block have encroached on ED 'resuscitation capacity' with periods of time experienced without resuscitation beds being available to commence resuscitation for a new peri-arrest patient Many instances of patients still critically-ill prematurely moved out of a resuscitation bay prior to complete stabilisation to allow a newly arrived patient to commence their own resuscitation have been reported. Occasionally, ED staff have been forced to stretch themselves across multiple simultaneous resuscitations in non-commissioned bed spaces resulting in a diminished quality of resuscitation for those they are juggling. ED staff are placed under tremendous stress shuffling patients in and out of other ED beds in this manner just to be able to meet the ED primary function of 'saving lives'.

The queue of non-critical patients waiting for assessment and initial care progressively build up in these situations resulting in ED overcrowding. Many instances of delayed initial care due to the inability to access an appropriate treatment space amidst severe overcrowding have been reported; in some cases resulting in patients deteriorating to cardiac arrest and succumbing to their illness without having had access to an ED bed initially. There have been many specific examples discussed at hospital clinical councils or morbidity and mortality meetings.

The impact on safety of patient care by ED overcrowding is a well-studied and documented phenomenon nation-wide due to the lack of resources or processes to cater for high numbers of presentations. The SWSLHD-MSC is greatly concerned safety is being compromised by the relative lack of beds and physical treatment spaces during extremely high levels of access block.

Emergency Department beds and treatment spaces are not designed for prolonged patient care or comfort; yet patients are housed in them for lengthy periods of time waiting for their specialty inpatient hospital bed to come up and for all the while not receiving the specific care their conditions require to resolve the acute episode. In many cases the delays in receiving specific management lead invariably to a lengthening of their overall hospital length of stay. In particular for SWSLHD where subspecialist services are not present in all its facilities, patients requiring tertiary/quaternary care then subsequently require a secondary transfer to the specialist hospital, the access block for these patients often amount to multiple days, incurring the 'double-whammy' of suffering from delays in their own care as well as contributing to the consumption of ED accessible beds whilst waiting in transit.

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

The SWSLHD-MSC has observed that since the pandemic began, usual preventative and primary care provided by General Practitioners (GPs) has significantly diminished in South Western Sydney with many patients forced to attend our EDs knowing full well they have to enter often overcrowded waiting rooms and have to be prepared for long wait times just to be seen. In particular for mild acute respiratory and infectious illnesses which prior to the pandemic, GPs would readily manage in the community to prevent the need for ED attendance for those with mild to moderate illness, the concern for the potential for an acute COVID-19 incursion for GP surgeries and medical centres, despite widespread vaccination, swabbing clinics, RATs, PPE and telehealth options, many ED presentations reportedly still occur from a patients' inability to access a GP appointment. The SWSLHD-MSC however acknowledges the challenges GPs face to ensure their surgeries and medical centres remain viable whilst trying not to charge gap payments as private specialists do. In SWSLHD, due to inflation and rises in mortgage interest rates, it is expected more families will struggle financially than ever before and a decrease in access to bulk-billing GPs will result in more ED presentations to contribute to ED overcrowding. Of most concern is the neglect of the health management of patients with Chronic & Complex conditions who without regular GP-supervised care, accelerated progression of their diseases occurs and inevitably results in more frequent public health system encounters with ED presentations in more compromised states, necessitating acute hospital admission and contributing further negatively to the access block issue.

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

In SWSLHD, a major contributor of up to 50% of long length of stay (LLOS) inpatients of more than nine days are awaiting residential aged care facility (RACF) placement. These patients are usually no longer or were never acutely unwell and have families

or social situations that indicated a long time previously the need for nursing home placement but had been unable to access for it.

Aged Care Specialists in SWSLHD report a disparity in access to Commonwealth Aged Care Assessment Teams (ACATs) and subsequent package approval to the funding of resources to facilitate them remaining in their own homes or in the community with support s long as possible. Younger patients with disability in South Western Sydney have minimal support services to receive assistance for their National Disability Insurance Scheme (NDIS) applications and even less resources to engage even when their NDIS application haven't been rejected. Due to long waits for ACAT and NDIS applications, both groups often present to the SWSLHD EDs in crisis resulting in the need for hospital admission and joining the sizeable group of long length of stay patients taking up acute hospital beds when no acute medical issue is actually present. The SWSLHD-MSC wonders why the State acute hospital system should have to shoulder the burden of the deficiency of ACAT and NDIS care packages and allied health service providers in the community.

The SWSLHD-MSC is concerned nursing homes in South Western Sydney have insufficient levels of Registered Nurse (RN) staffing and minimal After-Hours GP (AHGP) support to review perceived changes in clinical status or manage transient minor issues as they arise to minimise unnecessary ED transfers contributing to ambulance ramping. Adequately resourced and coordinated Community Outreach Geriatric Support (COGS) services for nursing homes may improve ED & Hospital avoidance.

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

In SWSLHD EDs, patients presenting using their own means or transported by friends or family members often find themselves in direct competition with patients arriving by Ambulance Service NSW (ASNSW) to access an ED treatment space. Not infrequently, the later arriving but potentially less ill ambulance patient is preferentially offloaded into an ED bed to relieve the ramping queue even though it is recognised that a potentially more ill patient left in the Waiting Room, Triage or Clinical Initiatives Nurse (CIN) areas. Whilst this assists the return of ambulances and their crews back out to the community it places a significant burden on the ED staff who carry the clinical risk of ED overcrowding managing a group referred to as 'over census' patients. During after-hours, the only time an over census acutely ill patient overrides an ambulance patient ordered by the hospital manager in being offloaded is if the patient has deteriorated sufficiently to cause concern for imminent cardiorespiratory peri-arrest. Clinical examples can be provided if requested.

Access block impact upon mental health patients in particular, can be very challenging if not outright detrimental for both their physical and mental well-being. Often acute destabilisation of chronic mental health illnesses is precipitated by stressors in the community. Subsequently being housed in yet another high stress-provoking environment such as our EDs, increased levels of agitation and higher rates of triggering unintentional violence and aggression is often proportionate to the overall duration of their ED length of stay putting all patient and staff groups at unnecessary risk of physical harm.

The stress endured by ED staff juggling the demands in the overcrowded ED during periods of access block is enormous and deserving of more acknowledgement than they currently receive; being on constant watch for an acutely ill patient not in an appropriate ED clinical space waiting to arrest has taken its toll on many and through burnout and despondency, there has been an attrition of senior nursing and medical staff not easily visible to those outside of the public hospital system as they are often quickly backfilled by junior staff who are yet to accumulate the judgement, skills and experience veterans leaving the frontline have acquired to reliably ensure safety in the uncapped and overburdened EDs. It is an unpalatable situation that is very likely to worsen as more and more of the ED workforce burnout.

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

The application of 'short term escalation plans' otherwise known as 'STEPs' is only as effective as the name implies – short term. Although well-intentioned and able to help improve communication between frontline clinicians and administrators, the SWSLHD-MSC has not viewed them as effective being merely descriptive and without leverage to relieve pressure on ED staff when faced with the challenge of an overcrowded Emergency Department. Rather, in some instances, staff have felt despondent when raising safety concerns regarding excessive numbers of accumulated Waiting Room or CIN patients waiting for beds or treatment spaces when bed allocation for those who arrive via private transport is reprioritised by hospital managers and re-allocated to ramped ambulance patients to release them back into the community. The measurement of a facility to offload ambulances known as 'transfer of care' or 'TOC' is a KPI reported by facility and LHD to the Ministry. There is no similar KPI for a patient needing an ED treatment space who has perhaps helped their community by not utilising an ambulance and self-transported themselves to the hospital to be placed in an appropriate treatment space. Patients with chronic illnesses familiar with ED systems have learnt to 'game' their ED presentation by calling for an ambulance despite having other reliable means to attend the ED with the knowledge they are more likely to be granted a bed by taking this pathway.

Matrices categorizing increasing pressures in the EDs based on demand and capacity designed to communicate sitreps to offsite executives (See Appendix 1) help provide a necessary common language to facilitate STEPs and initiate forms of escalation when required. However, over time when EDs are left constantly in the most extreme and dire of situations for an ED – STEP 3 (See Appendices 3 & 5), disengagement of the clinical staff and further despondency has occurred as the Emergency Matrix and the STEPs are mostly descriptive with no leverage or authority to recruit assistance or trigger pressure relief for EDs. Often the resources of the system have already been utterly consumed and depleted with no fresh reserves on standby to be called upon.

During business hours (See Appendices 2 & 4), inpatient teams are coerced to discharge patients as quickly as possible to create ED accessible beds to meet immediate demand. However, for Chronic & Complex patients with multidisciplinary needs that haven't been adequately met, the premature discharge becomes painfully evident and even more burdensome for ED staff when the patient

represents almost as if they had attempted to leave via a revolving door. Especially when outpatient allied health services have been redeployed to perceived higher priority acute patients as a strategy to facilitate rapid discharges, their absence from core maintenance and rehabilitative services further contributes to the diminished capacity to maintain a Chronic & Complex patient well-being in the community resulting in the same patients representing to the ED in crisis for readmission.
Whole of Health (WOH) strategies within each facility to encourage inpatient hospital teams to facilitate the flow of patients moving through the facility has had varying levels of success and attention over the past decade.
Short term successes have been fuelled predominantly by 'good faith' and hope that maximising the few resources some departments possess to improve flow and decrease access block have relatively been unrewarded leading to diminished engagement and collaboration when 'cost-neutral' gains have been thoroughly maximised and requests for additional resourcing to further improve flow receive no funding.
The SWSLHD-MSC seeks 'longer term' plans to address this now chronic issue. The 'bricks & mortar' approach with capital works to create much needed physical infrastructure to grow services and create bed capacity over the long term predictably suffers the problem of implementation lag. The serial processes of funding approval and then recruitment of staff to operationalise the extra spaces will take months if not years to come to fruition. Meanwhile, the glistening reflective windows during the day and neon lights at night atop the high-rise modern architecture beckons patients like moths to a flame who then attend the EDs expecting the new facility before them have beds readily available for them but are unaware that in the initial phases of commissioning, the likelihood of them experiencing less access block in comparison with their previous experiences is invariably the same as departments move in to their new home wards 'like for like'. In some cases, the move into a new clinical space is associated with a reduction in ED accessible beds; the same number of inpatient beds are physically built, but if spread over a larger floorplan with more subdividing walls or corridors, paradoxically more staff is required to safely manage them.

(g) Strategies, initiatives and actions that NSW Health should consider addressing the impact of ambulance ramping, access block and emergency department delays

The SWSLHD-MSC recommends for consideration as part of the solution to ambulance ramping and access block:

1. Accelerate resourcing SWSLHD's hospitals to commission all wards and services outlined in the SWSLHD Clinical Services Plan[2] (CSP) to better meet demand
2. NSW Health refocus on ED & Hospital Avoidance strategies for patient groups predicted to frequently access acute hospital care
3. NSW Health takes some responsibility for the care of patients with Chronic & Complex conditions to create the required difference to health care to prevention hospital utilisation and provide early discharge safety nets for all those unable to be afford care in the private setting. Significant expansion of specialist public hospital ambulatory services including the employment of specialists with adequate support staff and the provision of adequate clinical space. This may require further negotiation with the Commonwealth to form

better partnerships in the provision of public hospital outpatient specialist clinics. In other States, these activities occur utilising the Medicare framework in public hospitals; often to a far greater degree than they do in NSW.

The SWSLHD-MSC does not support the implementation of Urgent Care GP Clinics (UCCs) diverting LHD resources as a strategy to reduce ambulance ramping and access block when there is an Australasian College of Emergency Medicine (ACEM) accredited Emergency Department available. Historically, the AHGP clinics co-located with EDs did not reduce ED overcrowding after-hours nor affect ED length of stays (EDLOS) for patients with acute illness requiring inpatient hospital admission. Contrary to popular belief, Australasian Triage Scale (ATS) Category 4 & 5 patients are not necessarily low acuity nor automatically non-complex. Undifferentiated patient presentations given Category 4's & 5's occasionally carry significant morbidity and even mortality.

Patients presenting with minor injuries to EDs and GP-type patients do not represent a significant burden for ED staff nor contribute significantly to ambulance ramping or access block as they usually do not require acute cardiorespiratory monitoring nor inpatient hospital admission[3]. Resources allocated to focus on diversional strategies for this patient subset serve EDs better by being directed at activities to reduce delays for higher acuity patients presenting who invariably will need hospital admission.

The SWSLHD-MSC believes that without innovative service development and coordination between our hospital based systems, the Primary Health Network (PHN) and other community-based services to develop Models of Care (MoC) to better manage subacute care overburdening the acute hospital and provide chronic care services in order to prevent acute admissions, the ongoing struggles resulting in ambulance ramping and access block for patients who ultimately have no other option than to seek their health care via our SWSLHD EDs will never come to an end.

In summary, the SWSLHD-MSC believes the solution to resolving ambulance ramping and access block on Emergency Departments involves a State commitment to provide adequate numbers of permanent ED accessible beds commensurate with population distribution and growth as well as accessible and affordable health service capacity in the community to prevent crisis ED presentations amongst those vulnerable with Chronic & Complex conditions and investing in ED & Hospital Avoidance MoCs.

We would be more than willing if called upon to provide further testimony and evidence at the Hearings in this Inquiry and very much look forward to seeing its results and recommendations alleviate the pressures felt by our invaluable and hard-working staff in the EDs.

Yours Truthfully,

The South Western Sydney Local Health District Medical Staff Council Chairs

References (non-appendixed)

1. Bureau of Health Information (BHI) reporting – www.bhi.nsw.gov.au
2. South Western Sydney Local Health District Abridged Clinical Services Plan for Macarthur to 2031 (2017 version)
3. Australasian College for Emergency Medicine Position Statement - Access Block version 4 (updated March 2021)

Appendix 1. Example of SWSLHD Emergency Department & Emergency Short Stay Unit Short Term Escalation Plan – Matrix

Triggers	Business as Usual		S.T.E.P. 1		S.T.E.P. 2		S.T.E.P. 3	
	Score	0	Score	1	Score	2	Score	3
Largest Impact								
Ambulance. Ability to Offload NSW Ambulance	Nil delays		***Delay expected*** 1 Resus bed available and 1 acute/UCC bed available within 15 mins		***Delay imminent*** 1 Resus bed available only with No Acute/UCC bed becoming available within 15 mins		***Delay imminent*** Nil offload capacity with no plans	
All admitted Patients in ED *minus* patients with "bed ready" icon (Including MH, ,ESSU queue and IHTs)	<10 patients		11-15 patients		16-20 patients		>20 patients	
Presentations PREDICTED Predicted presentations	<200		201-220		221-240		>240	
Presentations ACTUAL Presentations in previous 2 hours	<20		20-30		31-40		>40	
Total Patients in ED All areas, including Waiting room	<50		51-65		66-80		>80	
Wait to Be Seen (Waiting to see Doctor)	<10		11-20 patients		21-30 patients		>30 patients	
Acuity Active resuscitations in ED OR Resus Capacity *(unable to decant)*	Nil active Resus OR 3-4 Resus beds available		Nil active Resus OR 2 Resus beds available		1 active Cat 1 resus OR 1 Resus bed available		2 active Cat 1 resus OR No Resus bed available	
Moderate Impact								
Inpatient admissions in ESSU (COVID) Unallocated admitted patient in ESSU incl IHTs	0-1		2		3		>3	
ED LOS and ED Turnover Patients in ED >8 hours	1- 4 patients		4- 8 patients		9 - 12 patients		>12	
Workforce								
Medical	Roster covered		Deficit Registrar/RMO x 1		Deficit Staff Specialist x 1 OR Registrar/RMO x 2		Deficit Staff Specialist x 2	
Nursing	Roster covered		Deficit 1 area not covered (RN/EN x 1)		Deficit of Nurse Practitioner x 1 OR Nurse Navigator/UCC CNS2 x 1		Deficit of 1 area not covered plus deficit of NP/NN/CNS2 OR Deficit of 2 areas not covered (RN/EN x 2)	
Wards persons (EDSO)	Roster covered		Deficit x 1 in AM/PM		Deficit x 1 Night Shift		Deficit x 2 in AM/PM	
Other risks								
Internal Emergency eg. eMR/FirstNet, CT Scanner, Pathology, Medical Gases					Planned Internal Emergency (ie. Planned downtime of service)		Unplanned Internal Emergency (ie. Unplanned loss of service)	
		0-3		4 - 10		11 - 17		>17

Appendix 2. Example of SWSLHD Emergency Department & Emergency Short Stay Unit Short Term Escalation Plan – Action Card for Business hours BAU & STEP 1

TRIGGERS	BUSINESS AS USUAL	WHO	Actioned	MODERATE COMPROMISED	WHO	Actioned
Ambulance Ability to offload NSW ambulance	Monitor Ambulance Arrivals Board for pending demand	ED NUMCO DM		Prioritise offloads where safe	ED NUMCO	
	Review Ambulance demand since midnight and predicted activity, and consider ongoing risk	EXEC HUDDLE NM ED DM		Facilitate transfer of allocated patients to wards	ED NUMCO ED NAV	
				Utilise 1 x overcensus strategy on wards to create capacity	DM	
				Identify discharges that can be transferred to DTU to create capacity	ED NUMCO ED SS	
	Communicate offload plans via text to designated managers via escalaton process	ED NUMCO		If WARD delays for transfer, escalate to PFM or DM	ED NUMCO	
				If CLINICAL delays with allocated patients, consider re-allocating available beds to patients who are clinically stable.	ED NAV ED SS PFM	
				Ward delays to be escalated to ward NUM or Team Leader	PFM DM	
				Monitor Ambulance ovverides and escalate to Ambulance HRM	NM ED DM ONM	
All admitted Patients in ED minus Patients with "bed ready" icon (Including MH, ,ESSU queue and IHTs)	Review ED queue and identify streams or specialities with high demand	ED NUMCO DM		Utilise overcensus strategy on wards to clear queue	DM	
	Review pending discharges on wards and update ePJB and G2G	WARD NUMS		Escalate Mental Health queue to MH PFM or AH NUM MH	ED NUMCO DM	
	Transfer any discharges to DTU as soon as possible (weekdays only)			Review delays for transfer to wards and escalate delays to NM ED or DM	ED NUMCO ED NAV	
	Any delays to discharge from wards escalate to DM			IHT Transfer delays from ED to be reviewed and escalated to receiving facility Demand Manager	DM ONM	
	IHT Transfers to be reviewed and escalated to receiving facility	PFM DM				
Presentations PREDICTED Predicted presentations	Review today's predicted presentations and predicted peaks	ED NUMCO DM		Ensure all ED staffing is adequately resourced for next 24 hours	ED NUMCO NM ED Dir. ED	
	Ensure all ED staff are aware of predicted presentations and predicted peaks	ED NUMCO NM ED		Review potential impact in light of other facility demands including predicted admissions and discharges from inpatient beds	DM ONM	
	Review current tracking against prediction - recalculating escalation level if required	ED NUMCO DM		Review current tracking against prediction - recalculating escalation level if required	ED NUMCO DM	
Presentations ACTUAL Presentations in previous 2 hours	Monitor other flow indicators for impact of rapid presentations (clustering) - WTBS - Total patients in ED - Ambulance offloads	ED NUMCO DM		Review Wait to Be Seen (doctor) queue and associated actions requires (see actions)	ED NUMCO ED SS	
				Review current tracking against prediction - recalculating escalation level	ED NUMCO	
Total Patients in ED All areas, including Waiting room	Identify any risks or barriers to ED flow, leading to increased volume in ED	ED NUMCO ED SS		Monitor other flow indicators for impact of increased volume in ED - WTBS - Admit queue	ED NUMCO NM ED DM	
	Monitor predicted demand against current volume in ED	ED NUMCO DM		Review barriers to ED flow and other flow indicators, taking action as required (see associated actions)	ED NUMCO ED SS	
Wait to Be Seen (Waiting to see a Doctor)	Review and monitor as required	ED NUMCO ED SS		Monitor risk to patient and staff safety	ED NUMCO NM ED	
				Monitor risk to increased volume in ED, decreased patient flow, and to Ambulance offload		
				Consider barriers to flow in other areas of ED (see associated actions)		
				Escalate risks to NM ED and ED SS		
				Escalate to PFM if ED capacity is compromised	NM ED ED SS	
Acuity Active resuscitations Resus Capacity						
Inpatient admissions in EDSSU Unallocated admitted patients in EDSSU	Evaluate delays to determine action needed	ED NUMCO ED NAV		Review patients idenitfied as inpatient admisisons and escalate to admitting team if patient could be discharged	ED SS	
	Consider risks to ESSU flow	ED NUMCO		IHT Transfer delays from ED to be reviewed and escalated to receiving facility Demand Manager	DM	
	IHT Transfers to be reviewed and escalated to receiving facility	PFM DM				
	Identify discharges that can be transferred to DTU to assist with creating capacity	ED NUMCO ED SS				
LOS & ED Turnover Number of patients ED LOS >8 hours.	Ensure all patients ED LOS >8hrs have plan to admit or discharge	ED NUMCO ED SS		Review ED processing delays that are impeding flow through discharge stream	ED NUMCO ED SS	
	Escalate radiology delays to Radiology Navigator or Team Leader	ED NUMCO ED NAV		Escalation of barriers (eg Radiology, Mental Health, PTS) to NM ED, Demand Manager or ONM	ED NUMCO ED NAV	
	Any PTS or IHT delays escalate to PFM or Demand Manager			Escalation of barriers (eg Radiology, Mental Health, PTS) to appropriate managers, Department Head or Executive on Call	NM ED DM ONM	
	Identify discharges that can be transferred to DTU to assist with creating capacity			If delays in Admit stream (see associated actions under "All admitted Patients in ED)	ED NUMCO DM	
Workforce All Workforce relating to any ED roles	Review rosters for next 24 hours or weekend ahead	ED NUMCO NM ED Dir.ED		Escalate any deficit to appropriate staffing manager	ED NUMCO NM ED Dir.ED	
				Review deficit in light of predicted or actual demand and consider risks		
Internal Dependency Delays Radiology - Pathology - IT systems non-functional	Ensure all ED staff are aware of any planned downtime, anticipated duration and impact, and strategies, actions and support planned to manage during downtime period	ED NUMCO NM ED ONM Dir.ED		Ensure communication to relevant teams when planned downtime begins		
				Monitor ongoing impact to flow and patient saefty throughout downtime		
				Escalate delays as appropriate (see associated actions)		
				Ensure planned downtime does not exceed planned timeframe		

Appendix 3. Example of SWSLHD Emergency Department & Emergency Short Stay Unit Short Term Escalation Plan – Action Card for Business Hours STEP 2 & 3

TRIGGERS	SEVERE COMPROMISE	WHO	Actioned	EXTREME COMPROMISE	WHO	Actioned
Ambulance Ability to offload NSW ambulance	Rounding in ED to review all delays and barriers to flow	ED NUMCO ED SS		Executive (or delegate) led risk huddle to review risks to safety, access to care and transfer of care.	ONM	
	Identify internal or external influences that are impeding flow eg WTBS, Radiology, PTS, Mental Health and escalate accordingly to NM ED			Consider ANSW Matrix adjustment and escalate to LHD DONM&P for discussion/approval	GM	
	Escalation of barriers (eg Radiology, Mental Health, PTS) to NM ED, Demand Manager or ONM					
	Escalation of barriers (eg Radiology, Mental Health, PTS) to appropriate managers, Department Head or Executive on Call	NM ED Dir. ED DM ONM				
	Discuss Ambulance distribution with LHD SAM and Ambulance HRM	DM ONM				
	Utilise enhanced 2 x overcensus strategy on wards to create capacity	ONM				
All admitted Patients in ED minus Patients with "bed ready" icon (Including MH, ESSU queue and IHTs)	Review ED processing delays that are impeding admisisons decisions or delaying transfer to ward (eg Radiology delays, use of Admission policy)	NM ED Dir. ED ED SS		Escalate unallocated IHT to receiving Facility Executive to expedite bed allocation and transfer	DMS GM	
	Use of Admission Policy to be escalated to Dir. Emergency Medicine	ED NUMCO ED SS DM		Escalate unallocated Mental Health admits in ED to receiving Mental Health Executive to expedite bed allocation and transfer	DMS GM	
	Ongoing IHT Transfer delays in ED to be reviewed and escalated to receiving facility ONM and LHD SAM	DM ONM		Use of Admission Policy to be escalated to Dir. Medical Services	Dir. ED	
	Queue for Mental Health beds to be escalated to MH ONM			Consider need to postpone theatre cases to redirect capacity to ED admissions	ONM DMS GM	
	Request all medical teams with admissions queued in ED to round in the ED and facilitate safe discharges Dir.ectly from the ED	Dir. MEDICINE DMS				
	Review inpatient capacity and consider the need to increase (surge)	ONM				
	Review Emergency Theatre queue and DOSA demand (see FACILITY actions)	DM ONM				
Presentations PREDICTED Predicted presentations	Ensure resources align with predicted peaks presentations requirements to minimise impact of predicted demand	NM ED Dir. ED		Consider reallocation of other resources to reduce impact of peak periods	ONM EXECUTIVE DIRECTORS	
	Consider extra resource requirements to minimise impact of predicted demand	DM ONM				
	Ensure all Dir.ectorates are aware of the predicted demand and potential impact on service delievery	ONM MSOM Dir. AH Dir. CORP				
	Review current tracking against prediction - recalculating escalation level if required	ED NUMCO DM				
Presentations ACTUAL Presentations in previous 2 hours	Consider redeployment of indirect ED clinical staff to clinical areas to assist with front-door actions (eg Triage, CIN)	NM ED Dir. ED		Consider Radiology capacity and extending operating hours of Radiology to avoid backlog.	DMS	
	Review ongoing impact on ED flow and other indicators (i.e. Total patients in ED, WTBS queue, Ambulance offload)	ED NUMCO NM ED		Review current tracking against prediction - recalculating escalation level (see associated actions)	NM ED ONM	
	Review ongoing impact on Radiology flow	DM ONM				
	Review current tracking against prediction - recalculating escalation level					
Total Patients in ED All areas, including Waiting room	Monitor risks to patient and staff safety and mitigate accordingly	ED NUMCO NM ED Dir. ED ONM		Executive (or delagte) led risk huddle to review risks to safety, access to care and transfer of care.	ONM	
	Consider increased resources for ED to maintain safety and improve flow in ED	ED NUMCO NM ED Dir. ED				
	Consider increased resource requirements to maintain safety and improve flow across facility	DM ONM MSOM				
	Consider pending risk to Ambulance offload capacity (see associated actions)	ED NUMCO NM ED DM				
Wait to Be Seen (Waiting to be seen by Doctor)	Evaluate causes of increased wait to be seen time	NM ED Dir. ED		Escalate risks to DMS	Dir. ED ED SS	
	Consider short-term reallocation of resources within ED to assist with front door flow			Consider risks in view of other ED flow indicators (See associated actions)	DMS	
	Escalate risks to ONM or DMS					
Acuity Active resuscitations Resus Capacity	Ensure all areas of ED remain safe during time of deployed resources for Resus	ED NUMCO		Evaluate risk to patient and staff safety	NM ED	
	Monitor risk to Ambulance offload (see associated actions)	ED NUMCO DM		Escalate risks to ONM	NM ED DM	
	Consider barriers to flow in other areas of ED that may impede access to care for other patients	ED NUMCO		Evaluate risk to Ambulance offload (see associated actions)	NM ED ONM	
	Escalate risks to flow or safety to NM ED			Consider reallocation of resources within ED	NM ED ONM	
	Identify patients in Resus to be decanted	ED NUMCO ED SS		Consider reallocation of resources within facility to assist	ONM	
	Facilitate urgent decision-making for admission	ED SS		Consider redeployment of Senior Medical Staff (eg Med Reg, ICU Reg) to ED to assist with decision-making	DMS	
	Escalate to PFM or Demand Manager if ED flow is compromised	ED NUMCO				
	Assist with decanting ED and Resus through bed allocation and transfer to inpatient wards	PFM				
Inpatient admissions in EDSSU Unallocated admitted patients in EDSSU	Ongoing IHT Transfer delays in ED to be reviewed and escalated to receiving facility ONM	ONM		Consider need for surge beds to facilitate ward admissions from EDSSU	ONM	
	Consider overcensus beds in inpatient wards to acocomodate admits in EDSSU	DM				
	Request admtting inpatient team to review patients in EDSSU for possible discharge directly from EDSSU	MSOM DMS Dir. MEDICINE Prof SURGERY				
LOS & ED Turnover Number of patients ED LOS >8 hours.	Escalate queue to NM ED	ED NUMCO		Escalate queue to ONM and Dir. ED	NM ED ED SS	
	Escalation of barriers (eg Radiology, Mental Health, PTS) to appropriate Executive Dir.ector or Executive on Call	ONM		Escalate barriers to flow Dir. Medcial Services or required Department Heads, or Executive on Call	ONM Dir. ED	
	If delays in Admit stream (see associated actions under "All admitted Patients in ED)	ED NUMCO ED NAV DM				
Workforce All Workforce in ED	Deficits not rectified to be escalated to appropriate Executive Director	NM ED Dir.ED		Consider need to deploy resources from other areas of the facility	GM EXEC DIRECTORS	
	Consider need for overtime					
Internal Dependency Delays Radiology - Pathology - IT systems non-functional	Ensure communication when planned downtime begins	ED NUMCO NM ED Dir.ED ONM		Activate required downtime procedures	ED NUMCO NM ED Dir.ED ONM	
	Monitor ongoing impact to flow and patient saefty throughout downtime			Escalate immediately - do not delay		
	Escalate delays as appropriate (see associated actions)			Monitor ongoing impact to flow and patient safety during downtime		
	Ensure planned downtime does not exceed planned timeframe			Escalate delays and impact as appropriate (see associated actions)		
				Determine timeframe to be rectified and monitor		

Appendix 4. Example of SWSLHD Emergency Department & Emergency Short Stay Unit Short Term Escalation Plan – Action Card for After Hours BAU & STEP 1

TRIGGERS	BUSINESS AS USUAL	WHO	Actioned	MODERATE COMPROMISED	WHO	Actioned
Ambulance Ability to offload NSW ambulance	Monitor Ambulance Arrivals Board for pending demand	ED NUMCO AHNM		Prioritise offloads where safe	ED NUMCO	
	Review Ambulance demand since midnight and predicted activity, and consider ongoing risk	AHNM		Facilitate transfer of allocated patients to wards	ED NUMCO ED NAV	
				Utilise 1 x overcensus strategy on wards to create capacity	AHNM	
				Identify discharges that can be transferred to DTU to create capacity	ED NUMCO ED SS	
	Communicate offload plans via text to designated managers via escalaton process	ED NUMCO		If WARD delays for transfer, escalate to PFM/DM or AHNM	ED NUMCO	
				If CLINICAL delays with allocated patients, consider re-allocating available beds to patients who are clinically stable.	ED NAV ED SS AHNM	
				Ward delays to be escalated to ward Team Leader	AHNM	
All admitted Patients in ED minus Patients with "bed ready" icon (Including MH, ,ESSU queue and IHTs)	Review ED queue and identify streams or specialities with high demand	ED NUMCO AHNM		Utilise overcensus strategy on wards to clear queue	AHNM	
	Review pending discharges on wards and update ePJB and G2G	TEAM LEADERS WARDS DMU NAV		Escalate Mental Health queue to AH NUM MH	ED NUMCO AHNM	
	Any delays to discharge escalate to AHNM			Review delays for transfer to wards and escalate delays to AHNM	ED NUMCO ED NAV	
	IHT Transfers to be reviewed and escalated to receiving facility	AHNM		IHT Transfer delays from ED to be reviewed and escalated to receiving facility Demand Management Unit	AHNM	
Presentations PREDICTED Predicted presentations	Review today's predicted presentations and predicted peaks	ED NUMCO DM AHNM		Ensure all ED staffing is adequately resourced for next 24 hours	ED NUMCO ED SS AHNM	
	Ensure all ED staff are aware of predicted presentations and predicted peaks	ED NUMCO AHNM		Review potential impact in light of other facility demands including predicted admissions and discharges from inpatient beds	AHNM	
	Review current tracking against prediction - recalculating escalation level if required	ED NUMCO AHNM		Review current tracking against prediction - recalculating escalation level if required	ED NUMCO AHNM	
Presentations ACTUAL Presentations in previous 2 hours	Monitor other flow indicators for impact of rapid presentations (clustering) - WTBS - Total patients in ED - Ambulance offloads	ED NUMCO AHNM		Review Wait to Be Seen (doctor) queue and associated actions requires (see actions)	ED NUMCO ED SS AHNM	
				Review current tracking against prediction - recalculating escalation level	ED NUMCO AHNM	
Total Patients in ED All areas, including Waiting room	Identify any risks or barriers to ED flow, leading to increased volume in ED	ED NUMCO ED SS AHNM		Monitor other flow indicators for impact of increased volume in ED - WTBS - Admit queue	ED NUMCO AHNM	
	Monitor predicted demand against current volume in ED	ED NUMCO AHNM		Review barriers to ED flow and other flow indicators, taking action as required (see associated actions)	ED NUMCO ED SS	
Wait to Be Seen (Waiting to be seen by Doctor)	Review and monitor as required	ED NUMCO ED SS AHNM		Monitor risk to patient and staff safety	ED NUMCO	
				Monitor risk to increased volume in ED, decreased patient flow, and to Ambulance offload		
				Consider barriers to flow in other areas of ED (see associated actions)		
				Escalate risks to AHNM and ED SS		
				Escalate to AHNM if ED capacity is compromised	ED NUMCO ED SS	
Acuity Active resuscitations Resus Capacity						
Inpatient admissions in EDSSU Unallocated admitted patients in EDSSU	Evaluate delays to determine action needed	ED NUMCO ED NAV		Review patients identified as inpatient admissions and escalate to admitting team if patient could be discharged	ED SS	
	Consider risks to ESSU flow	ED NUMCO		IHT Transfer delays from ED to be reviewed and escalated to receiving facility AHNM	AHNM	
	IHT Transfers to be reviewed and escalated to receiving facility	AHNM				
	Identify discharges that can be transferred to DTU to assist with creating capacity	ED NUMCO ED SS				
LOS & ED Turnover Number of patients ED LOS >8 hours.	Ensure all patients ED LOS >8hrs have plan to admit or discharge	ED NUMCO ED SS		Review ED processing delays that are impeding flow through discharge stream	ED NUMCO ED SS	
	Escalate radiology delays to Radiology Navigator or Team Leader	ED NUMCO ED NAV		Escalation of barriers (eg Radiology, Mental Health, PTS) to NM ED, Demand Manager, ONM, or AHNM	ED NUMCO ED NAV	
	Any PTS or IHT delays escalate to PFM, Demand Manager or AHNM			Escalation of barriers (eg Radiology, Mental Health, PTS) to appropriate managers, Department Head or Executive on Call	NM ED DM ONM AHNM	
	Identify discharges that can be transferred to DTU to assist with creating capacity			If delays in Admit stream (see associated actions under "All admitted Patients in ED)	ED NUMCO DM AHNM	
Workforce All Workforce relating to any ED roles	Review rosters for next 24 hours or weekend ahead	ED NUMCO ED SS AHNM		Escalate any deficit to appropriate staffing manager	ED NUMCO ED SS AHNM	
				Review deficit in light of predicted or actual demand and consider risks		
Internal Dependency Delays Radiology - Pathology - IT systems non-functional	Ensure all ED staff are aware of any planned downtime, anticipated duration and impact, and strategies, actions and support planned to manage during downtime period	ED NUMCO AHNM EoC				

Appendix 5. Example of SWSLHD Emergency Department & Emergency Short Stay Unit Short Term Escalation Plan – Action Card for After Hours STEP 2 & 3

TRIGGERS	SEVERE COMPROMISE	WHO	Actioned	EXTREME COMPROMISE	WHO	Actioned
Ambulance Ability to offload NSW ambulance	Rounding in ED to review all delays and barriers to flow	ED NUMCO ED SS		Executive (or delegate) led risk huddle to review risks to safety, access to care and transfer of care.	AHNM	
	Identify internal or external influences that are impeding flow eg WTBS, Radiology, PTS, Menatl Health and escalate accordingly to NM ED			Consider ANSW Matrix adjustment and escalate to LHD EoC for discussion/approval	EoC	
	Escalation of barriers (eg Radiology, Mental Health, PTS) to NM ED, Demand Manager or ONM					
	Escalation of barriers (eg Radiology, Mental Health, PTS) to EoC	AHNM				
All admitted Patients in ED minus Patients with "bed ready" icon (Including MH, ESSU queue and IHTs)	Review ED processing delays that are impeding admisisons decisions or delaying transfer to ward (eg Radiology delays, use of Admission policy)	ED NUMCO ED SS		Escalate unallocated IHT to receiving Facility Executive on Call to expedite bed allocation and transfer	EoC	
	Ongoing IHT Transfer delays in ED to be reviewed and escalated to receiving facility AHNM	AHNM		Escalate unallocated Mental Health admits in ED to receiving Mental Health Executive on Call to expedite bed allocation and transfer	EoC	
	Queue for Mental Health beds to be escalated to MH AHNM	AHNM				
	Review inpatient capacity and consider the need to increase temporarily (surge)	AHNM EoC				
	Review Emergency Theatre queue and next day DOSA demand (see FACILITY actions)	AHNM				
Presentations PREDICTED Predicted presentations	Review current tracking against prediction - recalculating escalation level if required	ED NUMCO AHNM		Review current tracking against prediction - recalculating escalation level if required	ED NUMCO AHNM	
Presentations ACTUAL Presentations in previous 2 hours	Consider redeployment of indirect ED clinical staff to clinical areas to assist with front-door actions (eg Triage, CIN)	ED NUMCO		Review current tracking against prediction - recalculating escalation level (see associated actions)	ED NUMCO AHNM	
	Review ongoing impact on ED flow and other indicators (i.e. Total patients in ED, WTBS queue, Ambulance offload)	ED NUMCO AHNM				
	Review ongoing impact on Radiology flow	ED NUMCO AHNM				
	Review current tracking against prediction - recalculating escalation level					
Total Patients in ED All areas, including Waiting room	Monitor risks to patient and staff safety and mitigate accordingly	ED NUMCO AHNM		Executive (or delegate) led risk huddle to review risks to safety, access to care and transfer of care.	AHNM	
	Consider increased resources for ED to maintain safety and improve flow in ED	ED NUMCO ED SS AHNM		Escalate ongoing risk to EoC	EoC	
	Consider increased resource requirements to maintain safety and improve flow across facility	AHNM				
	Consider pending risk to Ambulance offload capacity (see associated actions)	ED NUMCO AHNM				
Wait to Be Seen (Waiting to be seen by Doctor)	Evaluate causes of increased wait to be seen time	ED NUMCO ED SS		Escalate risks to EoC	AHNM	
	Consider short-term reallocation of resources within ED to assist with front door flow			Consider risks in view of other ED flow indicators (See associated actions)		
	Escalate risks to AHNM					
Acuity Active resuscitations Resus Capacity	Ensure all areas of ED remain safe during time of deployed resources for Resus	ED NUMCO		Evaluate risk to patient and staff safety	AHNM ED NUMCO ED SS	
	Monitor risk to Ambulance offload (see associated actions)	ED NUMCO AHNM		Escalate risks to EoC	AHNM	
	Consider barriers to flow in other areas of ED that may impede access to care for other patients	ED NUMCO		Evaluate risk to Ambulance offload (see associated actions)	AHNM	
	Escalate risks to flow or safety to AHNM			Consider reallocation of resources within ED	ED NUMCO ED SS AHNM	
	Identify patients in Resus to be decanted	ED NUMCO ED SS		Consider reallocation of resources within facility to assist	AHNM EoC	
	Facilitate urgent decision-making for admission	ED SS		Consider redeployment of Senior Medical Staff (eg Med Reg, ICU Reg) to ED to assist with decision-making	EoC	
	Assist with decanting ED and Resus through bed allocation and transfer to inpatient wards	AHNM				
Inpatient admissions in EDSSU Unallocated admitted patients in EDSSU	Ongoing IHT Transfer delays in ED to be reviewed and escalated to receiving facility AHNM	AHNM		Consider need for surge beds to facilitate ward admissions from EDSSU	AHNM	
	Consider overcensus beds in inpatient wards to acocomodate admits in EDSSU	AHNM		Ongoing IHT Transfer delays in ED to be reviewed and escalated to receiving facility AHNM	EoC	
LOS & ED Turnover Number of patients ED LOS >8 hours.	Escalate queue to AHNM	ED NUMCO		Escalate barriers to flow Executive on Call	AHNM	
	Escalation of barriers (eg Radiology, Mental Health, PTS) to AHNM	ED NUMCO				
	If delays in Admit stream (see associated actions under "All admitted Patients in ED)	ED NUMCO ED NAV				
Workforce All Workforce relating to any ED roles	Deficits not rectified to be escalated to AHNM	ED NUMCO ED SS		Consider need to deploy resources from other areas of the facility	AHNM EoC	
	Consider need for overtime					
Internal Dependency Delays Radiology - Pathology - IT systems non-functional	Ensure escalation when planned downtime begins	AHNM		Activate required downtime procedures	ED NUMCO EDSS AHNM EoC	
	Monitor ongoing impact to flow and patient saefty throughout downtime			Escalate immediately - do not delay		
	Escalate delays as appropriate (see associated actions)			Monitor ongoing impact to flow and patient saefty throughout downtime		
	Ensure planned downtime does not exceed planned timeframe			Escalate delays and impact as appropriate (see associated actions)		
				Determine timeframe to be rectified and monitor		