Submission No 29

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

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Date Received: 13 September 2022

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ASMOF NSW Submission: Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

Introduction

> *'Access block has reached a critical point where the treatment that patients require is so delayed that there is now a never-ending spiral of work. The longer patients stay in ED, the longer they wait for the inpatient specialist care they require, the longer they stay in a bed without adequate nursing ratios to provide food, water, medication...'*
>
> *'The community, in this case the vulnerable and sick, are being harmed due to neglect by NSW Health and the federal government by inaction on this front.'*

ASMOF NSW represents over 5000 medical staff, from interns to staff specialists, working across public hospitals in NSW. Our members working in Emergency Medicine are on the frontline of this crisis, but it ultimately impacts all our members who are urging the NSW Government to address this crisis and increase capacity across our health system.

Our submission addresses the terms of reference with a particular focus on the concrete solutions that will address the root causes of access block to improve the delivery of health care in NSW. While access block is most visible in the Emergency Department (ED), the solutions are to be found outside of the ED.

Doctors have provided eight priority solutions to access block for the NSW Government to action:

1. Increase inpatient bed capacity
2. Improve medical staff working conditions through Award upgrades
3. Monitor and address work health and safety concerns in Emergency Departments
4. Increase availability of hospital outreach programs
5. Consistent admission and discharge protocols across NSW
6. Equitable access to outpatient clinics
7. Better access to high quality aged and disability care
8. Improve transport and pharmacy options for patients awaiting discharge

ASMOF has consulted with doctors working across NSW public hospitals to develop this submission, and quotes from our members are included in text boxes throughout the submission.

a) the causes of ambulance ramping, access block and emergency department delays;

'The causes of all of these problems boils down to one simple issue: lack of inpatient hospital beds [to put the ED patient into].'

Ambulance ramping is a response designed to limit the number of patients entering the ED when it is already overcrowded. Whereas this once was used as an occasional stopgap, hospitals have now come to rely upon ramping as an answer to ongoing systemic failures.

When we look for the causes of ambulance ramping, we are ultimately looking for the causes of ED overcrowding- **which is that there are not enough inpatient hospital beds for the number of admitted patients**. Once all the hospital beds are full, the patients stay in ED, and when the ED beds are full, they stay on ambulances.

Ambulance ramping is a symptom of our health system in distress, and it is ultimately a sign of our hospitals and community health services being overloaded and unable to provide normal patient care

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

'We can no longer say that we have "the best health system in the world" when people wait for increasingly long times for basic services.'

'When bed occupancy reaches 100%, the system becomes dysfunctional'.

Emergency Departments do not function when they are overcrowded, and the literature on this demonstrates the need for spare capacity to be built into the system in order for it to function properly and allow for normal fluctuations in demand. Ideal occupancy should be no more than 85%, and once capacity exceeds 95%, care is significantly compromised.

Currently, in NSW, hospitals routinely run at greater than 100% capacity or close to 100% capacity.

It is routine for EDs in New South Wales to have a large number of admitted patients waiting for a bed at 8am. Often this number exceeds the total number of ED bed spaces, not counting ambulatory care assessment zones. For example, if you have an ED with 21-bed spaces and 18 admitted patients at 8am waiting for a ward bed, you are functionally working with a three-bed ED - the 18 patients are actually ward patients. There are also hospitals in the Sydney metropolitan area where ward patients boarding in the ED exceeds the total number of ED spaces. In this situation the ED is operating with a negative bed base.

This leads to emergency departments becoming increasingly crowded and ambulances unable to offload.

The impact of overcrowded EDs on patients and staff will be considered further in section e)

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

It is a common myth that EDs are full of patients that could have had their care needs addressed by a GP. These patients do not contribute to ED overcrowding as most of these patients can be quickly treated and discharged in designated low-acuity, fast-track areas of the emergency department. They do not occupy ED bed spaces nor do they consume significant amounts of ED resources- there is no evidence to support that access block is contributed to by GP-type patients presenting to ED.

The biggest problem with the increasing lack of access to GPs is that patients with chronic and complex care who don't get timely intervention from a GP will end up getting sicker and will therefore need to be admitted to hospital further down the track.

For this reason, regular access to affordable GPs is a critical part of our overall health system function.

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

'There are less residential aged care beds in many health districts available than there were 3 years ago…the waiting list for aged care packages in the community are often longer than the life expectancy of the patients we are requesting them for.'

'[Patients] will end up on waiting lists for aged care services or placement prior to discharge. These patients will often have 7-28 days longer length of stay, and in some cases more than 3 months, than what usually would be required to manage their acute problem while waiting for community-based services from NDIS, My Aged Care, or a residential aged care bed. Solutions to manage these patients in the community setting are diminishing.'

Availability and access to aged care and disability services in the community has a significant impact on hospital function and contributes to access block.

Lack of access to these services causes significant delays in patient discharge. A stable patient who is ready for discharge, but requires significant aged care or disability services, will stay unnecessarily in hospital until those services are organised and available. This leads to a patient inappropriately occupying a hospital inpatient bed, contributing to access block and ED overcrowding.

There are hospitals across NSW with at least 40 to 50 patients waiting for aged care placement, which could easily make up greater than 10% of the inpatient hospital bed base.

Doctors have identified that the NDIS has also become particularly problematic over the last few years, with significant delays to planning meetings and funding approval, resulting in discharge delays.

Improved access to community-based aged care, disability & mental health services is also essential to keep our community healthy and out of hospital in the first place. Frequently

there are significant delays in services. For example, aged care assessments typically take 12-18 months. During this time, patients deteriorate, are at risk of falls, and may require hospital admission. If they can't pay for carers from their own money or transport to access medical services, they may end up in hospital.

The capacity of Residential Aged Care Facilities and NDIS care providers to provide adequate medical support to patients is also important in preventing hospitalisation.

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

Impact on patients

The impact of overcrowding and access block on patients is of significant concern to ASMOF members. Our medical staff are unable to provide the safest, most timely and appropriate care for patients under these conditions.

It is important to note that the ED is staffed for the number of beds without any reference to the number of patients who may be in the ED at any one time. While the ED itself may technically be fully staffed, there will not be staff for patients in the waiting room, which may be holding 40+ patients on a bad day.

A significant body of evidence demonstrates that when EDs are overcrowded, patients receive worse care, are at greater risk of harm and end up staying in hospital longer. Patients in NSW are currently experiencing significant delays in accessing care. These prolonged waits in EDs expose patients to a greater risk of hospital-acquired complications, such as contracting COVID, pressure areas and medication errors.

Patients left in ED more than 24 hours also do worse due to sleep deprivation and not being assessed appropriately.

Ambulance ramping specifically results in delays to care for patients who have not come to the ED via ambulance- those on ambulance stretchers get a bed over those in the waiting room, which leads to an increased risk to those patients in the waiting room. The physical clutter of paramedics and stretchers in the corridor poses a fire, evacuation risk, increased noise pollution and confusion.

It can also lead to confusion over the responsibility for care for patients on stretchers – who may not be having observations or receiving appropriate pain relief.

Impact on Emergency staff

ASMOF holds serious concerns that current staffing and workload levels across most Emergency Departments pose a significant risk to health and safety. ASMOF has been involved in a number of industrial matters across the state which suggest that LHDs are regularly contravening their obligations to:

- provide a safe and healthy work environment; and
- ensure so far as is reasonably practicable, the health and safety of staff, and patients is not being put at risk from the way that work is being carried out.

The inability of staff to provide the best care possible also leads to significant psychological stress, moral injury, and burnout in both nursing and medical staff.

The effects of overcrowding and overwork and on our members working within the ED is characterised by stress, feelings of helplessness, depression, anxiety, burnout and eventually leads to a high turnover of staff and difficulty attracting new staff to a psychologically and physically unsafe working environment.

These sentiments are reflected in quotes from our members:

'Ramping has negative effects on everyone's morale.'

'Emergency department staff are either stuck taking care of already-stabilised patients waiting to be admitted or forced to see the newly arriving sick and unwell in chairs, corridors or side rooms, often with no other support.
It's not surprising to see emergency department staff moving to other areas, reducing their hours or leaving the field entirely due to the toll of overcrowding.'

'This push from hospital executive teams to expect higher output from a diminishing workforce under higher demand working conditions is leading to elevated levels of fatigue, work dissatisfaction, disengagement, and burnout. With this elevated level of workload / work related stress leads to clinical errors, lower efficiency, and resignations. The focus on short term gain is leading to long-term harm.

'Hospital staff have been expected to work for free at times, in some cases after the fact. With this level of disregard for staff wellbeing from executive teams, hospital staff go into a state of self-preservation/protection to avoid harm to themselves.'

Improving the wellbeing and safety of our staff will be critical to addressing the crisis in our hospitals.

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

'Hospitals are now so tightly run they are as efficient as they can be. Therefore, there are now minimal efficiency gains that can be made, akin to the theory of diminishing returns.'

'Any strategy that involves allowing the ED footprint to accept more and more patients without increasing resources is akin to simply building a bigger toilet when your toilet is blocked.'

ASMOF members have expressed frustration at solutions implemented by NSW Health which address the symptom of access block and ramping without addressing the root causes. A number of these measures have been undertaken by NSW Health, including:

- opening up additional areas in the emergency department
- assigning a “transfer of care” nurse to watch over patients arriving by ambulance in order to put paramedics back on the road
- designating medical and nursing teams to rapidly assess and initiate treatment on newly arriving patients who do not have assigned beds.
- paramedic teams that come and look after multiple ambulance patients so that road crews can get back on the road to bring more patients to the ED.
- offload zones where ambulances can offload patients into an ambulance offload zone, separate to any kind of ED clinical area, again looked after by paramedic staff so that road crews can get back onto the road

While some of these initiatives have provided some temporary relief, they have not been sustainable and have ultimately been an ineffective substitute for the lack of available inpatient hospital beds.

Other measures have been introduced without adequate staffing and long-term resources that would allow them to be effective.

g) drawing on other Australian and overseas jurisdictions, possible strategies, initiatives and actions that NSW Health should consider to address the impact of ambulance ramping, access block and emergency department delays

SOLUTIONS

1. Increase inpatient bed capacity

‘Open more staffed, inpatient ward beds and the access block disappears: Admitted patients will move out of the emergency department. There will be fewer emergency department delays as the entire ED is now available to treat emergencies. And ambulance ramping will disappear as there will be beds for arriving ambulances to offload.’

‘There will always be some incremental efficiencies that can be developed to discharge hospital inpatients more quickly to free up more inpatient beds – but the bottom line is that hospitals need more staffed inpatient beds.’

The most obvious immediate solution to this crisis is to increase inpatient bed capacity and ensure that NSW hospitals are not operating above 95% of their capacity.

A sustained lack of investment in health from Australian Governments has led to a situation in which most major hospitals in Sydney now have significantly fewer beds than they did in the 1970s, despite growing demand. The continual decline in public hospital bed numbers has been reflected in the AMA Public Hospital Report Card which has revealed that in 2017-18, the ratio of public hospital beds for every 1,000 people aged 65 years and older declined for the 26th consecutive year to 16.0. One hospital bed per 1,000 population aged 65 years or more has been lost in just the last two years.

Doctors particularly identified rehabilitation beds and palliative care beds as being in high demand and needing to be expanded to decrease the pressure on our system.

Whilst increasing bed capacity is not the only solution, it is critical to making any meaningful impact on access block, ramping and ED overcrowding.

As well as sustained funding for more beds, NSW Health must be able to recruit and retain the increase in staff required to manage these beds.

2. *Improve medical staff working conditions through Award upgrades*

> *'the hospital has less resources for these interventions than we had 3 years ago due to our great resignation of senior staff during the pandemic and constant sick leave from respiratory virus isolation periods'.*

To effectively increase hospital and health service capacity, NSW Government must improve the retention and recruitment of medical staff at all levels.

Staffing of hospital wards is currently at an all-time low. In October 2021, ASMOF NSW surveyed 813 senior doctors in public hospitals across the state, and 76% reported staff shortages in their departments. The COVID-19 pandemic has exacerbated staff shortages as staff are more frequently off sick, and many are burned out from overwork and have left the public sector entirely.

The poor working conditions faced by our doctors-in-training, in particular, who are working on the frontline of our EDs, have received increasing attention over the past two years, with a cascade of media reports drawing attention to system failures that junior doctors bear the brunt of. Both junior and senior doctors are speaking out about these unacceptable conditions and a system that has failed to protect junior doctors from exploitation, bullying and burnout. There are several legal actions against the NSW Government in motion, including ASMOF NSW legal action on behalf of hundreds of doctors who have worked significant unpaid overtime.

Despite this attention, very little has changed in doctors working lives. It is no longer an attractive option for doctors to work in public hospitals in NSW. Due to the NSW Wages Policy, there has been no meaningful improvement to the industrial Award in over 35 years, and NSW has fallen far behind other states and territories. It is no wonder doctors are choosing to leave the state or work as locums or Visiting Medical Officers, where the pay and conditions are favourable. With the departure of every salaried doctor, even more, pressure is put on existing staff.

Doctors in NSW deserve Industrial Awards that are up-to-date and fit for purpose. ASMOF recommend that these fundamental working conditions be improved to ensure that safe medical staffing levels can be maintained so our hospitals are safe for patients and staff.

3. *Monitor and address work health and safety concerns in Emergency Departments*

> *'As a clinician, there is no standardised definition of an unsafe work environment and this is a system failing that other industries do not tolerate.'*

Public hospitals do not currently prioritise and ensure accountability for work, health and safety management. In many hospitals ASMOF has found that there is

- a culture of accepting WHS risk
- a lack of resources available for hospital staff to consistently comply with WHS policy and procedures and work safely,
- inadequate WHS information provided to staff

Workplace safety must be discussed as a priority in discussing the causes and consequences of ambulance ramping and access block.

We recommend that there be strict compliance with and monitoring of Emergency Departments to ensure they are meeting the requirements of the *Work Health and Safety Act 2011.* Safe Work NSW should be better resourced to specifically monitor WHS compliance in EDs across the state.

We also call on the NSW Government to establish a working group comprising NSW Health, Safe Work NSW and key stakeholders, including representatives from the Health Unions (members of the Australian Salaried Medical Officers Federation, the Health Services Union, the NSW Nurses and Midwives Association) to develop strategies, priorities and initiatives to address the issue of understaffing, overwork, crowded work-spaces and the resulting unsafe work environments.

4. Increase availability of hospital outreach programs

'We need much more investment in outpatients and hospital in the home State and Federal governments need to increase their funding of public hospitals substantially and stop seeing them as a liability when they are, in fact an asset'

'improve the availability of General practitioners and Geriatricians to manage patients in nursing homes to prevent these patients presenting to ED for an assessment.'

There are a number of hospital outreach programs, including Hospital in the Home, Virtual Health and Geriatric Flying squad, which successfully prevent presentations to hospital from patients in Residential Aged Care Facilities and reduce hospital length of stay by getting patients home earlier. These programs are inconsistently available across NSW and typically under-resourced.

Public hospital doctors are calling for every LHD to have a system that provides these hospital outreach services with a central management to avoid duplication. We recommend that every LHD be given additional funding to ensure a full-time medical director and adequate nursing and medical staff to run these services seven days a week. This will ensure that RACFs are able to access medical staff for an in-person assessment, or access virtual care to assess whether they need to be transported to hospital.

These services also ensure that patients can have End of Life plans initiated instead of being transported to hospital (often against their wishes).

Hospital in the Home, Virtual Health care and other outreach programs are also well placed to accept referrals from GPs and EDs for diagnoses, such as respiratory infection, which can be effectively managed in the community.

Increased resourcing of these programs will also allow for improved IT systems. These IT systems facilitate good quality video health consults to nursing homes and residential facilities, allow GP practices to access ED and inpatients teams to review referred patients and make transfer decisions. High quality IT is important to patient care activities including reviewing wounds, reviewing paediatric respiratory distress, and having discussions with families before transferring patients to manage expectations and identify alternative options. Video health also allows for better outreach to regional hospitals to prevent unnecessary transfers for specialist care.

5. Consistent admission and discharge protocols across NSW

Currently, admission and discharge processes vary across NSW hospitals, and funding arrangements for admitting specialists can create disincentives for Visiting Medical Officers to discharge patients in a timely manner.

ASMOF NSW recommends that NSW Health adopt the Agency for Clinical Innovation's criteria led discharge guidelines and mandate that all hospitals use these guidelines.

In addition to standardised discharge processes across jurisdictions (criteria led discharge), standardised admissions processes are important. Every hospital should have an admission guideline in place that allows for seamless admission of patients without excessive review processes.

NSW Health has a Direct Admissions Policy that allows the ED to take control of the flow in the event of flow delay. This is a mandatory policy however it has been treated as discretionary in many jurisdictions.

6. Equitable access to outpatient clinics

Outpatient clinics provide specialist diagnosis and treatment services to patients presenting to the Emergency Department, and medical staff can refer patients to these clinics instead of admitting them to a bed on a ward. GPs working in the community can also refer patients to these clinics for urgent care.

These clinics provide bulk-billed and accessible healthcare to patients who may be experiencing conditions such as chest pain or mini strokes, many of whom can't afford private specialists and expensive tests, or may not be able to access this care urgently

For this reason, every LHD needs funding to run outpatient clinics effectively.

7. Better access to high quality aged and disability care

> *'The lack of services to discharge geriatrics or disability health service clients to is the leading cause of bed block'*

As outlined previously in this submission, there will always be a number of patients who need to be placed in an aged care facility or access an NDIS package, who end up being admitted to inpatient wards, where they often remain for lengthy periods of time.

The back-end discharge process in hospitals can be hastened by addressing the care needs of our elderly and dependant in the community by allowing rapid access to the equivalent of NDIS and My Aged Care packages that do not expire unless the patient recovers function.

8. Improve transport and pharmacy options for patients awaiting discharge

Transport and pharmacy is often a limiting step for patients awaiting discharge, particularly on weekends. ASMOF recommends that patients have 24/7 access to transport and pharmacy and that virtual links are provided to pharmacy when there is no on-site.