**Submission No 32**

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

**Organisation:** Rural Doctors' Association of New South Wales

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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**

**Submission on behalf of the Rural Doctors' Association of New South Wales**

The Rural Doctors' Association of New South Wales represents doctors working in regional, rural, and remote areas of New South Wales and advocates for the health of the communities they serve. Our members provide emergency and inpatient service in rural hospitals, including some areas of specialty service, and community general practice in our towns.

The association was formed over 30 years ago by a group of doctors who recognized emerging threats to the rural doctor workforce.

We have tried to draw attention to this problem and remark that there has been little tangible change in the way New South Wales Health goes about its business over this time. As has been remarked elsewhere it is not likely that continuing to do the same thing repeatedly will produce different outcomes. Many of these issues (facilities, workforce, both hospital and community, organisational problems) have already been addressed in the 2019 inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW and it is no surprise that the same issues feed through into the problem of ambulance ramping.

Ambulance ramping is not new and overcrowded emergency departments have been a feature of the health care system for some years.

Several papers over the years have pointed to the lack of beds in hospitals for patients to be admitted to from emergency departments as a considerable factor in the problem. Increase in bed numbers has not kept pace with increases in emergency department presentations year on year. (As a rough rule of thumb, it might be considered that the number of ambulances ramped is the number of extra hospital beds needed.)

Further down, the patient flow pathway this is compounded by difficulty in discharging patients from wards due to lack of appropriate community care and support. Lack of sufficient aged care has already been identified elsewhere as an impediment to discharging patients. Improvement in the supply of adequate rehabilitation services would also make a difference.

We also contend that the implementation of electronic medical records has perversely slowed the passage of patients through emergency departments and patient throughput per capita workforce.

Lack of access to general practice services in the community can also impact on the discharge process and the likelihood of readmissions. There is room for better coordination between hospital and community care.

Lack of access to GPs for low acuity care may increase the presentation of triage 4 and 5 patients to EDs and this is likely to increase wait times in the waiting room but would not seem to be related to the number of ambulances arriving, nor to bed block since very few triage 4 and 5 patients tend to be admitted. Also, ambulance arrivals are usually prioritized which would result in longer waiting room times rather than ramping.

It is not clear that lack of access to general practice has led directly to increased ED presentations. This assertion would need to be supported by data showing that the increase in ED presentations has outstripped population growth, adjusted for changes in the age structure of the population.

We sound a word of warning against trying to attribute ambulance ramping to a lack of general practice services. This is likely to lead to arguments about state or federal funding responsibilities while failing to address more fundamental issues.

Given that the problems giving rise to ramping appear to extend well beyond the ED it is likely that major re-evaluation of how we go about the business of health care provision will be needed.

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President
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