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NSW Inquiry into the Impact of Ambulance Ramping and Access Block

1. Summary

Ambulance ramping and access block is a symptom of a health system in crisis. When patients in the emergency department (ED) cannot be admitted to in-patient care due to a lack of available beds (referred to as access block), the ED does not have capacity to accept new patients arriving in ambulances. Access block manifests acutely in EDs but is a symptom of system wide dysfunction, poor system capacity, and inadequate in-patient flexibility to manage known demand (1).

The Australasian College for Emergency Medicine (ACEM; the College) acknowledges the importance of ambulances being available to respond to emergencies rather than being ramped outside a hospital. The College stresses that the ambulance ramping crisis and its related problems will not be addressed or resolved solely by creating larger EDs, rapid offload areas or procuring more ambulances.

A whole-of-hospital and whole-of-system approach is required to address access block and the resulting ambulance ramping. This means transformational change implemented across the entire health system is required, with the identification of solutions that are tailored to local needs. Greater funding must be provided to address shortages of hospital beds, workforce and extended-hours service provision to allow more efficient patient flow into and through the hospital system.

Health system pressures are most visible in EDs through access block. Access block is the most significant quality and safety issue facing EDs in NSW, impacting the efficiency of ED function and contributing to ED overcrowding and ambulance ramping. In the view of our members, ramping and access block are the worst they have ever been, with increasing concerns about patients deteriorating in the ambulance or in the waiting room.

1.1 About ACEM

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

1.2 Recommendations

1. The NSW Government commits to growing the health workforce across specialities, and implements policies to retain experienced staff.
2. Implement ACEM's [Hospital Access Targets](#) (HAT).
3. Improve hospital in-patient capacity to ensure that it matches community need, with occupancy rate goals of 90% to allow for surge capacity.
4. Implement dedicated discharge planners (or similar) within the hospital system with hospital executive backing.

5. Engage with and support Commonwealth Government-led process to reform primary care funding.
6. Provide additional staffing support to assist people with disability to access specialist disability accommodation in a timely manner.
7. Implement consistent KPIs for ambulance to ED off-loading.
8. Implement measures to ensure accountability for addressing access block is shared across hospital departments

2. Definitions

2.1 Ambulance ramping

Ambulance ramping occurs when ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to the hospital ED within a clinically appropriate timeframe, specifically due to lack of an appropriate clinical space in the ED. (2) In some jurisdictions, ambulance ramping is also referred to as 'off-stretcher time delays' or 'ambulance turnaround delays'.

2.2 Emergency department overcrowding

Emergency department overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical or staffing capacity of the ED, whether patients are waiting to be seen, undergoing assessment and treatment, or waiting for departure (1).

2.3 Access block

Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the emergency department (ED), **whose total ED time exceeds eight hours** because of a lack of inpatient bed capacity. This includes patients who were planned for an admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED (1).

2.4 Off-loading

Ambulance off-loading refers to an agreed process between ambulance services and ED staff when transferring patients from the ambulance stretcher into an appropriate area within the ED (2).

3. Background

Ambulance plays a vital role in patient care, including by providing essential emergency response services that stabilise and transport patients to EDs. In 2020/21, there were over 3 million ED attendances in NSW, of which nearly seven hundred thousand arrived by ambulance, air ambulance or helicopter rescue service (22.7%) (2). This was an increase of 10% since 2017/18 (3-4).

The interaction and handover of patients between the ambulance and ED staff is critical to ensuring that patients receive the correct treatment in a timely fashion. ACEM members report that their interactions with ambulance services are professional and that paramedics provide high quality care within their scope of practice. However, ambulance ramping challenges the traditional 'respond, stabilise and transport' focus of ambulance services and raises an ethical dilemma for paramedics, who are effectively being asked to continue to provide ongoing emergency medical care for the patient beyond the scope and time frame of their expertise (2).

Adverse patient outcomes, poor patient experiences and higher health system costs are associated with ambulance ramping. Some of these include:

- Delayed access to definitive assessment and care because of slowed ambulance response times (5-6), with new patients presenting to an ED having a 10% greater chance of dying when more than 10% of patients waiting for admission are access blocked (7);

- Delays in the timeliness of ambulance responses due to fewer crews available to cover the same geographic areas. These delays are captured in deteriorating response times for critical and emergent patients (5);
- Increased stress and interpersonal conflict between patients, paramedics, executives and ED staff (5);
- Adverse publicity leading to poor staff morale and negative public perceptions of the health system;
- Decreased privacy for patients, and reduced patient dignity;
- Increased workplace health and safety complications arising from having to use inappropriate spaces to treat patients;
- Increased harm occurring in the waiting room due to long waits and insufficient staffing to identify deteriorating patients; and
- Decreased staff wellbeing and job satisfaction leading to staff losses, particularly among specialists and senior nurses.

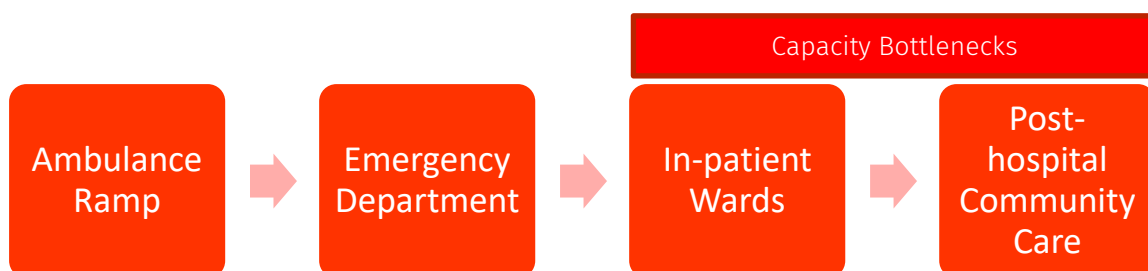
The long ED stays that result from access block and associated ambulance ramping create a disproportionate risk to be managed by ED and ambulance, and often hospitals are not prepared to level that risk across other departments. This is typically due to a lack of understanding and ownership of access block by in-patient teams and executives.

Often EDs (with ambulance as transport) are being conceived of as a single point of access to hospital, rather than as a location for emergency care, for instance using ED as a community sorting point for numbers of chronic health issues such as anaemia or ascites. Patients and staff also perceive that a focus on ambulance ramping means that walk-in patients are seen as a lower priority, leading patients to call ambulances in an attempt to receive faster care.

4. ACEM Position

To address ambulance ramping in a long term, sustainable way governments must increase investment in hospital and community-based services to improve patient flow.

Ambulance ramping is a direct consequence of insufficient in-patient capacity within the hospital. Solutions must focus on improving capacity on hospital wards to meet community needs, and to improve investment in community-based care to allow for earlier discharge into primary care.



There is too much focus on EDs finding ways to improve efficiency, and insufficient focus on the need to improve health system capacity. The complexity of the issue means there is no one single measure that will "fix" the issues. The hospital needs to be viewed as a whole, with solutions found to improve patient flow in and out of the hospital at all times. A whole of hospital response must include cultural change to clinical practices.

It is also essential to understand that low-acuity patients (sometime incorrectly referred to as 'GP type' patients) are not the cause of access block. Access block occurs due to patients who require inpatient care, not those who can be treated and sent home.

4.1 Solutions – Workforce

It is clear that one of the largest challenges facing the NSW health system is the retention of key medical and nursing staff.

The solutions presented in this submission all require sufficient staffing in the public and primary care systems.

Addressing workforce challenges is more than just looking at numbers of people in roles, it is about ensuring that the workforce is valued and treated with dignity. The current state of the workforce is that it is undervalued, overworked and the reservoirs of goodwill that helped steer the state through the worse of the COVID-19 pandemic are now largely depleted.

This is particularly evident in the loss of senior medical and nursing staff from a range of specialities, including emergency medicine. The combined experience that has been lost will take at least a decade to replace, as more junior staff upskill, and remaining senior staff take on additional work and risk.

Recommendation: The NSW Government commits to growing the health workforce across specialities, and implements policies to retain experienced staff.

4.2 Solutions – System Change

“If the pipe is blocked, the solution is not to build a bigger sink.” (Emergency Specialist)

A forthcoming review commissioned by ACEM and completed by the Sax Institute identified the following types of solutions that should be investigated and implemented:

1. Interventions to achieve reductions hospital bed occupancy. Many of these have been extensively implemented across NSW health services;
2. The establishment of short-stay units, acute medical units and acute surgical units, where patients admitted via an ED can be accommodated, typically for up to 72 hours, while receiving appropriate multidisciplinary specialist management prior to discharge or transfer to a subspecialty in-patient service;
3. Interventions to expedite patients’ transition through the ED/in-patient service interface. Decisions as to the subspecialty in-patient service that is to accept an admitted patient are often complex and can only be resolved by negotiations between ED staff and in-patient teams or between different in-patient teams. This results in delays and can create significant tension. The interventions include recognition of the different imperatives of ED staff and in-patient teams, processes to promote mutual understanding and respect, and leadership that promotes communication and a favourable working environment which is not dominated by power differentials among healthcare professionals;
4. The maintenance of health system-wide time targets for admitted and non-admitted patients’ transit through EDs, applied with sufficient flexibility to assure patient safety. The achievement of these targets depends on system and process changes which individually may not affect access block but are effective as combinations of initiatives within a performance-driven ethos (8).

4.3 Solutions – Improving Data

ACEM has developed ‘[Hospital Access Targets](#)’ (9), a new access measure that describes three patient streams and sets distinct targets for those streams. Hospital Access Targets are intended to reflect the complexity of patient needs and the diverse pathways patients may take following attendance at emergency department. The maximum length of emergency department stay recommended by Hospital Access Targets for any one stream is 12 hours.

For patients needing to be admitted to hospital or transferred to another hospital:

- ≥60% should have an emergency department length of stay no greater than four (4) hours;
- ≥80% should have an emergency department length of stay no greater than six (6) hours;

- ≥90% should have an emergency department length of stay no greater than eight (8) hours; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours.

For discharged patients:

- ≥80% should have an emergency department length of stay no greater than four (4) hours;
- ≥95% should have an emergency department length of stay no greater than eight (8) hours; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours.

For patients who need to be admitted to a short stay unit (SSU) for observation:

- ≥60% should have an emergency department length of stay no greater than four (4) hours upon SSU admission;
- ≥90% should have an emergency department length of stay no greater than eight (8) hours upon SSU admission; and
- 100% should have an emergency department length of stay no greater than twelve (12) hours upon SSU admission.

Recommendation: Implement ACEM's Hospital Access Targets.

4.4 Solutions – Hospital Capacity

The inadequate capacity of the hospital system is a fundamental contributor to ambulance ramping. In-patient wards require sufficient staff and beds to meet the needs of our ageing and increasing populations. Too often hospital systems are being run near 100% ward occupancy rather than systems that encourage total ward occupancy closer to 85-90%. By working to capacity, the system cannot meet the needs of emergency presentations, which flows back down to the ED with the symptoms of long wait times, access block and ambulance ramping occurring.

Capacity of hospitals and alternative care environments must be increased, including increasing the number of physical in-patient beds in public hospitals, extending in-patient and community services outside of normal business hours, increasing the size of the workforce to staff the additional beds and service capacity, and expanding models of hospital in the home. With all additional new services both in person and virtual care models, there needs to be increased staffing and space. Improved care in the community, for both primary care and tertiary services, will reduce reliance on the hospital system in the future and build a healthier population. An important focus of community-based services is residential aged care facilities, mental health care facilities, and specialist disability accommodation services.

Recommendation: Improve hospital in-patient capacity to ensure that it matches community need, with occupancy rate goals of 90% to allow for surge capacity.

Medical consultants are often the only people capable of admitting and discharging a patient. As their workload has increased, they often are unable to round on all their admitted patients each day. This means many patients are stuck in the ED waiting for a plan. If an in-patient team will not review admitted patients in the ED, the patient can go day waiting for bed before they even get a plan from a specialist. While this is happening, the bed and associated staff can't be seeing other patients, including those arriving by ambulance.

Significant improvements are required discharge practices and pathways out of hospital. This means an investment in appropriate step-down services that allow people to be discharged into appropriately funded primary care services, which improves hospital capacity for those that require it. This may be particularly challenging in regional areas, but conversely have the higher impact than in metro areas.

Dedicated discharge planners within the hospital system with appropriate social work, occupational therapy, physiotherapy, pharmacy and/or other allied health resources as necessary and hospital executive backing to enforce medical and surgical AMO disposition planning on day 1 of admission. There should be resources put into patients being discharged to residential aged care facilities - that patient's wishes for future care should be considered and clear guidelines for when/how to return to ED decided.

Recommendation: Implement dedicated discharge planners (or similar) within the hospital system with hospital executive backing.

4.5 Solutions - Primary Care Capacity

While we acknowledge that the NSW Government has limited ability to influence primary care capacity, nevertheless we must highlight the importance of reform in this area to achieve sustainable change. Access to appropriate primary care can prevent conditions from deteriorating to the point of requiring emergency care, yet the ability of General Practice to meet the needs of the population has been hamstrung by funding and structural issues for long periods, with the reduction in bulkbilling and gaps in primary care in some rural and regional areas of particular concern.

Recommendation: Engage with and support Commonwealth Government-led process to reform primary care funding.

A short-term complication is that many GPs are maintaining the policy of not seeing anyone with infectious symptoms meaning a significant part of their workload is falling to the ED, as well as impacting ambulance call-outs. There are also situations where GPs will refer patients to the ED as it is a 'one-stop shop' for diagnostics which may be more convenient for the patient.

Lack of adequate support in the community for elderly patients leads to greater admissions to the hospital, typically via the ED and arriving by ambulance. Limited clinical oversight in aged care means increased and unnecessary ambulance presentations. Aged care placement needs are a daily issue. There are not enough aged care beds available to service the need. In-patients can spend considerable time waiting for placement (short or long term) and cannot step down from the acute care services and hence block acute beds.

Recommendation: Improve access to residential aged care facilities and provide support to elderly Australians to facilitate access.

There are similar issues relating to disability care. National Disability Insurance Scheme (NDIS) participants in hospital take an extraordinary time to be housed. Additionally, disability care with behavioural components can be very complex, leading to in-patient services refusing to take these patients, and significant ED lengths of stay as a result.

Recommendation: Provide additional staffing support to assist people with disability to access specialist disability accommodation in a timely manner.

4.6 Solutions – Response when Ramping Occurs

In addition to the systemic changes that are required, a whole of hospital response is required when ramping does occur, led by the executive and inclusive of all departments. EDs are currently held responsible for access block when the authority to resolve it lies elsewhere in the hospital. A cultural change is required to ensure that appropriate capacity is available to meeting community needs and that this must be driven with in-patient units.

Routine delays to ambulance offloading of over 30 minutes should trigger a systematic review of the hospital and ED. Any episode over 60 minutes should initiate an escalation policy and incident review, where emergency physicians have a responsibility to inform hospital management that patient care could be compromised, and hospital management has a responsibility to restore a safe working environment.

Recommendation: Implement measures to ensure accountability for addressing access block is shared across hospital departments.

ACEM recommends a uniform approach to data definitions and capture for ambulance service and ED activities, as they relate to arrival and clinical handover of patients. ACEM also recommends using agreed KPIs across Australia and Aotearoa New Zealand for all patients, ambulance services and acute health systems. ACEM, ambulance services and health authorities should agree on uniform definitions, nomenclature and KPIs for ambulance delays.

This will ensure accurate measurement of ambulance service and ED performance. It will also ensure the efficacy of service improvement initiatives are accurately assessed and comparable, allowing better reproducibility and roll out of important initiatives.

ACEM suggests that the following KPIs be adopted:

- Within 15 minutes of arriving at an ED, 85% of patients should have their clinical handover completed.
- Within 20 minutes of arriving an ED, 95% of patients should have their clinical handover completed.
- Within 30 minutes of arriving an ED, 100% of patients should have their handover completed (1).

Recommendation: Implement consistent KPIs for ambulance to ED off-loading.

5. Unsuitable Interventions

The forthcoming review by the Sax Institute noted ‘Some interventions have been proposed to address access block but do not appear to be effective. These interventions may have other benefits such as reducing ED overcrowding, improving the quality of acute care, increasing patient satisfaction with ED services, and increasing staff satisfaction. They include ‘pre-ED’ interventions that can divert many ED presentations to other sources of prompt health care in the community, and ‘within-ED’ interventions such as modifications to triaging and streaming arrangements, modifications to the roles and responsibilities of ED staff, process improvement programs, and enlarging the capacity of EDs’ (8).

Other solutions have been proposed that ACEM strongly opposes:

5.1 Rapid Offload

ACEM does not support policies that allow for ambulances to leave a patient in a transition area when there is no capacity with the ED to care for that patient. There have been occasions in other jurisdictions where ambulance services have considered moving to rapid offload model of care, whereby patients are left at the ED door without any transfer. In that model, the ambulance staff cease to continue emergency medical care so that they are able to respond to other emergencies in the community.

Hospitals and EDs are already backlogged and staffed by a workforce that are already under excessive pressure. This means rapid offload is a highly dangerous response, which will lead to greater harm and fewer patients receiving the care they need in a timely fashion.

Emergency clinicians are concerned these approaches will soon lead to the return of “corridor medicine” as part of our daily expectations, that patients in the waiting room will effectively be ignored in preference to patients in an ambulance and that non-clinician executives will attempt to direct clinical care.

5.2 Holding Tents

Another highly problematic solution that has been attempted is to leave patients in tents at the entrance to the ED, staffed by nurses and paramedics. ACEM strongly opposes this approach as it

does not address the causes of ambulance ramping. Additionally, it is likely that those spaces will fill to capacity quickly, with ambulances then ramping to get patients into the tents. In other words, it is just creating an additional ramp. Finally, they are likely to compromise the quality provision of emergency care as they hold groups of undifferentiated patients with unknown acuity. They certainly fall below the reasonable expectations for care that Australians hold.

Rather than housing undifferentiated patients outside the hospital, a more constructive investment would be in transit lounges between the ED and in-patient wards. In this case the patients will be stable, their needs will be known, and they will have received initial emergency care.

6. References

1. Australasian College for Emergency Medicine. Position Statement on Access Block (S127). Melbourne: ACEM 2018
2. Australasian College for Emergency Medicine. Position Statement on Ambulance Ramping (S347). Melbourne: ACEM 2018
3. Australian Institute of Health and Welfare. Emergency department care 2020-21 data. Canberra: AIHW 2022. Retrieved 31 August 2022.
4. Australian Institute of Health and Welfare. Emergency department care 2017-18: Australian hospital statistics. Health services series no. 89. Cat. no. HSE 216. Canberra: AIHW 2018
5. Hammond, E., Shaban R.Z., Holzhauser, K., Crilly, J., Melton, M., Tippet, V., Fitzgerald, G.J., Eeles, D., Collier, J. & Finucane, J. (2012). An exploratory study to examine the phenomenon and practice of ambulance ramping at hospitals within Queensland Health Southern Districts and the Queensland Ambulance Service. Queensland Health & Griffith University: Brisbane
6. Hitchcock, M., Crilly, J., Gillespie, B., Chaboyer, W/, Tippett, V., & Lind J. (2010). The effects of ambulance ramping on Emergency Department length of stay and in-patient mortality. *Australasian Emergency Nursing Journal*: 13(1); 17-24
7. Jones, P. G, van der Werf, B. (2020). Emergency department crowding and mortality for patients presenting to emergency departments in New Zealand. *Emerg Med Australas*. 10. doi: 10.1111/1742-6723.13699.
8. Sax Institute. Access block: a review of potential solutions. Sydney: Sax Institute (forthcoming)
9. Australasian College for Emergency Medicine. Solutions to Access Block. Melbourne: ACEM 2021