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for Emergency Medicine

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Submission to the Aeromedical Services WA Inquiry - October 2021

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide this submission to the Western Australian Department of Health on their Aeromedical Services WA Inquiry.

ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring that the highest standards of medical care are provided for all patients presenting to an emergency department (ED).

ACEM recognises that aeromedical services are an essential part of the health care system in Western Australia, particularly when considering the vast distances between many communities and health services. Communities in regional Western Australia are serviced by a wide range of health services with varying capacity and the need to transfer patients to tertiary hospitals for critical care is a common occurrence. EDs as well as the hospitals they are situated within, are heavily reliant on interhospital transfers to ensure that their patients receive appropriate care.

ACEM members report that there is generally good communication between regional hospitals and the Royal Flying Doctor Service (RFDS) for interhospital transfers. The process for contacting RFDS to request a transfer is working well on a clinician-to-clinician basis and this is facilitated by emergency medicine specialists being employed by RFDS. Greater communication about delays and updated transfer pick-up times would assist local clinicians to evaluate the options for the patient in the meantime. Similarly, there is scope for improved coordination with tertiary hospitals at the destination of the transfer. Members acknowledge that there will be occasions when delays are unavoidable but nevertheless, patients and hospitals would benefit from better communication to ensure that staff and beds are available for the incoming patients to avoid delays in transferring patients from the transport service.

The clinical governance arrangements in place with RFDS are generally considered to be good. While some members noted that there was scope to improve the alignment in protocols between hospitals and the RFDS, processes are already underway to achieve this. It was noted that some smaller aeromedical providers sometimes provide interhospital transfers and that the quality of those processes was far more variable and would benefit from greater clinical and contractual oversight. An area of uncertainty relates to a lack of transparency in how patients and transfers are prioritised by RFDS. This has been increasingly problematic as delays to transfers have increased.

The coordination of aeromedical services was identified as an area of improvement. There currently appears to be a disconnect between interhospital transfers as currently run by RFDS and other aeromedical services such as the helicopter services contracted by the Department of Fire and Emergency Services (DEFS). RFDS can request the assistance of the DFES rescue helicopters when they are unable to respond and it is within helicopter range. Improved coordination and linkages between services would enhance the ability of the suite of aeromedical services to flex to the needs of the community at any particular point in time. Appropriate clinical oversight from emergency physicians must support these decisions as a feature of any changes to coordination of aeromedical services.

It is important to recognise that primary retrievals from scene are very different to interhospital transfers. The ambulance service should at all times coordinate these rotary wing responses to primary scenes and additionally, this scarce rescue helicopter must not be misused to transfer low priority and inappropriate interhospital transfers. Attempts to improve coordination must understand that there are complexities

inherent in pre-hospital medicine and interhospital transfers should not impact the ability to provide 000 response via rotary wing to those who most need it.

Additionally, any changes to aeromedical services must also consider the context of ambulances services in regional Western Australia. As noted in our recent submission to the inquiry into ambulance services in Western Australia, our members based in regional areas also view the adequacy of the ambulance service as good and the care provided to patients as of a high standard, however, access to this care can be challenging, particularly in light of many transfers being undertaken by volunteer ambulance officers who can have significant limitations in terms of availability. Additionally, our regional members have expressed concern that the coordination of the ambulance service is centralised through Perth which has given the impression that staff administering ambulance calls have a variable understanding of healthcare in regional areas, which would also apply for central coordination of aeromedical services.

Currently there are a range of different authorities that will provide different services for patients, such as the ambulance service provider, the RFDS, and local health authorities. Although individually they generally function well, when a patient moves between sites and/or authorities, there is a risk that, without coordination of this function, there are significant delays to treatment that may result in negative patient outcomes.

Decreased wait times for transfers should be pursued as an outcome of this inquiry. Depending on circumstances, patients can wait for 24-48 hours for a transfer to occur. Staged transfers are common in regional hospitals because RFDS is often busy and there will be delays to transfers. For example, a small clinic that is nurse-led has a patient that needs tertiary services but RFDS can't collect them for several hours. As they can't safely keep a patient for a prolonged period time, the patient is transferred by road to regional hub for stabilisation and await aeromedical retrieval. There is significant risk when a double hand-over occurs.

For mental health patients, the waits can be even longer, especially for presentations that occur late in the week. These delays have negative impacts on patient welfare and the capacity of regional health services to continue to meet the needs of their communities. While improved coordination could assist with minimising these delays, increased capacity within aeromedical services as well as tertiary hospitals, will be required to improve response times and this should be accompanied by increased transparency in how funding is allocated to and utilised by, aeromedical services.

Efficient aeromedical services must also consider the capacity of the system that they are transferring patients to which is frequently and severely impacted by access block. Access block occurs when patients in the ED cannot be admitted to inpatient care due to a lack of available beds and staff. The ED then does not have capacity to accept new patients arriving in ambulances, nor from aeromedical services. This lack of ED capacity is an indicator of systemic health care dysfunction that reduces patient safety and increases the risk of adverse health outcomes.[1]

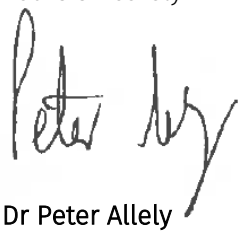
A whole-of-hospital and whole-of-system approach is required to address access block. This means transformational change implemented across the entire health system is required with the identification of system-wide clinical process redesign solutions that are tailored to local needs. ACEM is in the early stages of advocating for reforms to emergency access targets – namely NEAT which as a single point target, failed to recognise the different needs of ED patients – to hospital access targets as a new, flexible set of targets that will better reflect the nuances of different patient groups.

Access block manifests acutely in EDs but is a symptom of system wide dysfunction, poor system capacity and inadequate inpatient flexibility to manage known demand. Access block is linked to increased patient harm, most importantly morbidity and mortality, longer patient waiting times and hospital lengths of stay and, poor experiences of care[2,3].

Aeromedical services are impacted by access block decreasing their efficient and increasing unnecessary delays. It is not uncommon for patients transferred by aeromedical services to be ramped while trying to access metropolitan hospitals. In order to avoid this, capacity of hospitals and alternative care must be increased including increasing the number of physical inpatient beds in public hospitals, extending inpatient and community services outside of normal business hours and increasing the size of the workforce to man the additional beds and service capacity. 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.

Thank you again for the opportunity to provide feedback to this consultation. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact Jesse Dean, General Manager, Policy and Regional Engagement (jesse.dean@acem.org.au; +61 3 9320 0444).

Yours sincerely



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[1] Australasian College for Emergency Medicine (ACEM). Position Statement: Ambulance Ramping. Melbourne: ACEM; West Melbourne; 2018. Available from https://acem.org.au/getmedia/9e6c3e78-8cbc-473c-83df-474f6c1eecde/S347-Statement-on-Ambulance-Ramping-Nov-13.aspx

[2] Forero R, et al. Access block and ED overcrowding. Emerg Med Australas. 2010;22:119-135.

[3] Hammond E, et al. An exploratory study to examine the phenomenon and practice of ambulance ramping at hospitals within the Queensland Health Southern Districts and the Queensland Ambulance Service. Brisbane: Queensland Health & Griffith University; 2012.