Australasian College
for Emergency Medicine

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Public Administration Committee
Parliament House
4 Harvest Terrace
WEST PERTH WA 6005

By email: lcpac@parliament.wa.gov.au

Dear Committee members,

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide a submission to the Inquiry into the delivery of ambulance services in Western Australia (WA).

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.

The College commends the Committee for recognising the urgent need to review ambulance services in WA. We are in no doubt that this is in response to the record levels of ambulance ramping that have been occurring over the last six months.

Ambulance ramping is a symptom of a health system in crisis. When patients in the emergency department (ED) cannot be admitted to inpatient care due to a lack of available beds, the ED does not have capacity to accept new patients arriving in ambulances. 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]

The daily number of presentations to EDs and the proportion of patients needing admission to hospital from the ED is predictable (to within 10%), yet ambulance ramping has become concerningly worse in WA in recent years, with the situation being critical since the start of the year.[2]

The WA Emergency Access Target (WEAT) requires that 90 per cent of all patients presenting to a public hospital ED will be seen and admitted, transferred or discharged within four hours, yet in 2019-20 it took eight hours and 37 minutes for most (90 per cent) patients to depart the ED for inpatient beds.[3] This delay is in turn delaying the offload of new patients arriving in ambulances. It is also a patient safety issue, as recent research has shown that when more than 10% of ED patients required hospital admission are access blocked[4] (waiting more than eight hours for admission to an inpatient bed after ED care is complete), new patients arriving to that ED have a 10% greater chance of dying within seven days of presentation. Our access block snapshot survey across 10 EDs in WA in September 2020 found that 66 per cent of patients waiting for an inpatient bed were access blocked.

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 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.

The College has met with the Minister for Health, Roger Cook, on several occasions to discuss our concerns about the current situation in WA and our proposed solutions. The solutions needed for hospitals intersect closely with the scope of this inquiry and enacting them will reduce waiting times for patients, ease pressure on EDs, and in turn reduce the severity and frequency of ambulance ramping.

The College must stress that the ambulance ramping crisis and its related problems will not be addressed or resolved solely by channelling more resources into the ambulance service. Greater funding must be provided to the whole health system to address shortages of hospital beds, workforce and extended-hours service provision to allow more efficient patient flow into and through the hospital system.

Although emergency physicians do not have any direct involvement with ambulance calls, how they are administered has direct impact on EDs. Our members have reported that their interactions with the ambulance service are professional and have praised WA paramedics for the difficult jobs that they do. In particular, our members have singled out high quality structured and accurate clinical handovers, high quality pre-hospital care for patients, and the patient-centred approach that ambulance services are able to provide in WA, even when ramping is occurring. It has also been highlighted that the ambulance services are flexible and open to new approaches to care, such as with pre-hospital blood sample collections, which offer no benefit to paramedics, yet have been embraced widely.

The College also wishes to praise the WA ambulance service and paramedics for remaining with and providing care for patients during times of ambulance ramping. There have been occasions in other jurisdictions where ambulance services have considered moving to a 'dump and run' 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. While this may seem like a simple solution to ambulance ramping, due to hospitals and EDs that are already backlogged and staffed by a workforce that are already under excessive pressure, it is a highly dangerous response, that will lead to greater harm and fewer patients receiving the care they need in a timely fashion.

ACEM is also concerned about possible unintended consequences of the recently agreed contract between the WA Government and its ambulance service provider, which has linked funding to service demand.[5] Funding the ambulance service in such a way has potential to create a financial incentive for a greater number of ambulance presentations. Our members have not experienced an increase of ambulance patients that could have been managed elsewhere or remained home, however service provision must be audited to ensure that this does not occur.

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. This can manifest in situations where the central service does not understand the sheer distances and times involved in transporting patients to their destinations. While an initial call out may involve a three-hour journey to get the patient to their destination, the time for the ambulance crew to complete the job will likely take over double that amount of time, which can mean they are not able to respond to other calls for the majority of their shifts.

The view of our members is that adequacy of the service delivery model of ambulance services in metropolitan areas is good, but due to challenges outside the control of the ambulance service, efficiency is a problem. The efficiency of the service cannot be considered as good while unprecedented levels of ambulance ramping are occurring on a frequent basis due to a lack of hospital resources, resulting in access block and overcrowding manifesting in the ED as set out above. This is not due to the way in which the ambulance service is run.

The interaction and handover of patients between the ambulance and ED staff is also critical to ensuring that patients receive the correct treatment in a timely fashion. To that end, the College suggests that timely written clinical handovers are written into any future contact between the ambulance service and the State as a key performance indicator. Several serious clinical incidents have occurred where there have been prolonged timeframes before written ambulance reports were available to ED staff, and no solution has been implemented so far.

We are also aware of cases where the pressures on the ambulance service have resulted in patients outside of an ED catchment area, who have extensive clinical histories at other hospitals, being brought to different hospitals. The clinical matrix only allows for a history of two weeks, which has created situations where ED staff do not have immediate access to the clinical notes that they need in providing more informed and immediate care to patients. This in turn contributes to more overcrowding and longer waits in the ED, resulting in greater amounts of access block and ambulance ramping.

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. The efficiency of the service for patients being picked up by ambulances – often staffed by volunteers – and delivered to the nearest medical services was also cited as working well in general.

Interhospital transfer in regional areas is regarded as less successful. The service model that is used relies on volunteer ambulance crews, who will be undertaking their normal daily activities when they take a call. It has been reported to the College that there have been times when volunteers, and by extension an ambulance, are not immediately available when a transfer is perceived to not be urgent. Higher urgency patients tend to be responded to and transferred between care facilities quickly. This contrasts with lower urgency cases or mental health patients, where often there can be no crew available for the transfer for up to 24 hours. This requires care facilities to have to look for other options, which can mean requesting an ambulance crew from a different site or region (often limited to during business hours) or having to use the Royal Flying Doctor Service. This can mean that patients stay at sites without the appropriate medical staff or resources for up to 24 hours.

Consideration should be given to creating an independent coordination authority for patient service in regional areas. Currently there are a range of different authorities that will provide different services for patients, such as the ambulance service provider, the Royal Flying Doctor Service, 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 and negative patient outcomes.

Health system pressures are most visible in EDs through access block. Access block is the most significant quality and safety issue facing EDs in WA, impacting the efficiency of ED function and contributing to ED overcrowding and ambulance ramping.

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[6,7], with ACEM repeatedly calling on the WA Government to address this issue and adhere to pre-election promises on the matter.[8]

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.

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; 0423 251 383).

Yours sincerely,

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