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Submission to the Tasmanian Select Committee on Transfer of Care Delays (Ambulance Ramping)

November 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 20,000 physicians and 9,000 trainee physicians, across Australia and New Zealand, including 377 physicians and 134 trainee physicians in Tasmania. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of

the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Introduction

The RACP welcomes the opportunity to provide a submission to the Select Committee on Transfer of Care Delays (Ambulance Ramping) in Tasmania. This submission has been developed by the RACP Tasmanian Committee, which represents Tasmania physicians and trainees on a range of educational, professional development and advocacy issues.

Emergency access and transfer of care delays of long-stay disability and aged care patients are serious issues facing the Tasmanian healthcare system. RACP physicians are increasingly concerned about the number of patients who are medically cleared for discharge from hospitals in Tasmania but who are unable to leave due to a lack of suitable accommodation.

We note there is an established literature base examining ramping and clinical effects, including a position statement by the Australasian College of Emergency Medicine. We support reforms that improve patient outcomes, but we may have reservations about solutions that address only one part of the patient flow through a hospital system, and about solutions that address only the hospital-based parts of an interrelated health system covering preventive, community, and acute health care settings.

We need improved patient access and outcomes at a system level, not just better transfer metrics at one point in the system.

This submission has been informed by existing RACP policies and positions, and by the challenges and opportunities that physicians in Tasmania routinely observe in the course of their clinical and other duties. We thank the Select Committee for considering the points below, which address the Inquiry's terms of reference.

Key Messages

- Transfer of care delays are the product of insufficient resourcing throughout the health system including emergency departments, and the product of limited access to appropriate non-hospital supports including residential aged care facilities, disability services, and age appropriate care.
- Bed block in inpatient wards and in emergency departments has consequences beyond overcrowding, and is a strong driver of clinician burn out.
- Virtual health has the capacity to accommodate increased demand for healthcare and should be expanded.
- For appropriate patients and with appropriate design and governance systems, Hospital in the Home is a good practice alternative to providing care to a hospital-grade standard at a patient's home.
- Actions that must be taken by to address the causes and effects of transfer of care delays include:
    - Additional funding for public hospitals
    - Establishing Urgent Care Clinics in Tasmania that are well resourced and planned in collaboration with physicians to effectively reduce pressure on hospital services
    - Establishing more ambulatory multidisciplinary care clinics in the community
    - Implementing innovative integrated models of care involving specialists
    - Investing in the expansion of the Tasmanian specialist healthcare workforce.

TOR A: The causes of transfer of care delays, acknowledging Federal and State responsibilities

Transfer of care delays have multiple causes which require a range of solutions.

Insufficient resourcing of emergency department (ED) services and poorly accessible general practice services negatively effect ED waiting times. Physicians frequently work with patients after their progress through emergency departments or when admitted directly to medical wards. For this reason, we see transfer of care delays arising primarily due to barriers at the discharge end of patients' journeys through hospitals.

The availability of, and access to, quality residential aged care facilities (RACFs) and disability services is also a key factor particularly outside metropolitan Tasmania. RACFs are stretched and operate in an environment that has seen state government funding reductions to other providers of related services.[1] There is constant pressure to discharge patients from acute care facilities back to residential care. Residential care funding for higher care patients is insufficient and the level of resourcing is too narrow given the span of responsibility across residential aged care.

The RACP is concerned that some patients may remain in hospital for lack of appropriate accommodation or suitable disability or behavioural services – in some cases, for many months. Discharges can be delayed for non-clinical reasons; in other cases, discharge occurs to facilities that are not designed to meet the patient's needs. For example, it can take too long to provide post-hospital discharge care and accommodation for people who have intellectual disabilities and/or significant behavioural issues.

In addition, people with disabilities often require access to mobility aids, accessible communication, and appropriate resources.[2] A lack of access to any of these can cause significant delays to transfer of care. If family or other relevant people who may be needed for decision-making purposes are also not readily available, this too causes a delay to the delivery of healthcare that people with a disability need.

Consequently, patients often spend prolonged periods in acute hospitals with significant resources being required to ensure the safety of the person and other inpatients and staff. Acknowledging the complex interplay of clinical decision-making, administrative requirements, and relative paucity of options, delaying patients in acute care settings often serves them poorly, in addition to being a poor use of resource-intensive acute hospital services.

There is a gap in appropriate residential and care services for people under 65 years, including young and middle-aged adults, whose condition usually means they are currently accommodated in facilities that are neither designed nor suitable for them.

Post-discharge, ensuring patients have access to general practitioners and community-based physicians/paediatricians very soon after discharge for early follow up would help to significantly improve patient flow. This could be in the form of physician outpatient and/or GP models of care funded by the THS to remove the barrier of cost to patients for a post-discharge review. We also suggest that improving availability of same-day and next-day appointments, because often patients are admitted for review or further investigation when they could be managed in the early outpatient setting.

[1] RACP (2019) Submission to the Royal Commission into Aged Care Quality and Safety

[2] For example, please see the AHRC's 2020 Guidelines on the rights of people with disability in health and disability care during COVID-19 (including the section on involuntary hospital discharges for a consideration of circumstances when discharge is facilitated in unavoidable but suboptimal circumstances).

We also recommend improving supports for hospital-based clinicians when an adverse clinical outcome occurs in the event of a patient being discharged 'too early'. Awareness and experience of repercussions can drive risk-averse clinical decisions that yield longer lengths of stay for patients.

Major system level gains can be made by focusing on the transfer of care out of hospitals. The availability of geriatric medical and psychogeriatric services should be expanded, including by outreach and telehealth.

While we acknowledge that RACFs are predominately a Commonwealth responsibility, the Tasmanian Government can play an important role in improving the interface between hospital and residential care sectors, especially with regard to people with complex clinical and/or behavioural needs.

We see a similar role for the Tasmanian Government in providing the interface between hospital and residential and non-residential disability services – especially services that were, at the time of the NDIS's introduction, always intended to remain state responsibilities. Those services should expand as population and burden of disease/disability warrant.

RACFs must provide a large range of highly specialised services to younger and older patients which:

- Act as a specialist dementia service managing the full range of 'difficult to manage' behaviours.
- Provide high quality medical and nursing care to older people with highly complex care needs.
- Administer hospice care for the dying. RACFs often lack the physical environments or appropriately trained staff to facilitate good end of life care.
- Deliver medical, nursing, and behavioural management for younger people with brain injury and neurodegenerative diseases.
- Provide mental health service for older people with chronic cognitive and psychogeriatric problems, given that at least 54% of residents have dementia[3], many of whom have challenging behaviours which cannot be managed in physically unsuitable environments by staff with limited training.
- Provide a rehabilitation unit for people discharged from hospital with delirium or deconditioning resulting from acute illness. (See RACP submission to the Royal Commission into Aged Care Quality and Safety (December 2019), p. 41.)

Recommendations:

- Incorporate the recommendations of the Royal Commission into Aged Care Quality and Safety, where relevant and implementable by the Tasmanian Government.
- Develop a long-term statewide strategy for the provision of geriatric, disability, and related services for hospital and community settings.
- Adequately resource and support hospital based general medicine services with inpatient frameworks for managing patients with dementia.
- Work with the Federal Government to provide appropriate accommodation and care services for non-geriatric patients, people with intellectual disabilities, and people with dementia and related diseases.
- Fund and facilitate the development of outpatient clinical services in the community, that promote healthy aging, such as community transport for older people.
- Ensure adequate funding to build up community services for geriatric evaluation and home-based rehabilitation.

[3] Dementia in Australia Web Report, [Internet]. Australian Institute of Health and Welfare. 2023 [cited 2023 Nov 5]. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/aged-care-and-support-services-used-by-people-with/residential-aged-care

- Ensure RACFs provide a range of highly specialised and appropriate services to younger and older patients.

TOR B: The effect transfer of care delays has on the wellbeing of healthcare staff

Doctors' health and wellbeing is a key priority of the RACP. Bed blocked patients, who are overwhelmingly on inpatient wards and in emergency departments are a particularly strong driver of clinician burn out (including because physicians are poorly equipped to manage patients who have no needs from an acute hospital).

Burnout is an acute problem with critical consequences. We note that Tasmanian trainees within the RACP are simultaneously engaged in postgraduate specialist medical training and work in accredited training locations throughout the state's health system, and that this often brings unique stressors and pressures. Senior specialists are often consumed with clinical duties and supervision, impeding their ability to undertake ongoing professional development and conduct research. These factors have contributed to significant burnout throughout the physician workforce, including in Tasmania.

Burnout has been fuelled by a lack of appropriate or accessible resources, workforce shortages, and increased workload. Greater challenges in the regions have led to high staff turnover and greater reliance on locum doctors. The RACP Tasmanian Election Statement 2021 identifies workforce shortages as a key priority for the Tasmanian healthcare system and recognises the importance of fostering a culture of wellbeing for physicians and trainee physicians

TOR D: The State Government's response to transfer of care delays and its effects to date, and the efficacy of these measures

We support the intent and general direction of the Tasmanian Government's commitment to expand virtual health arrangements per the Digital Health - Improving Patient Outcomes Strategy 2022-2032. Virtual health has the capacity to accommodate increased demand, which must be considered against a backdrop of ageing and an increasing incidence of chronic disease in Tasmania.

We note one goal of the strategy is to deliver care closer to home "through solutions to strengthen the link between acute and community settings to enable consumers to receive appropriate care in their home for longer and avoid people going to hospital when they do not need to" (Digital Health Strategy, p. 21).

The best consultation modality, be it face-to-face, telephone, video or a mix is best negotiated between the clinician and the patient, with specific regard to their unique circumstances, the patient clinical presentation, risk and benefit. This is a position we strongly recommend be factored into planning for Tasmania's Digital Health Strategy so that it avoids the pitfalls of a one-size-fits all approach that fails to account for patient barriers to accessing video, as well as travel, attendance, or affordability constraints to attending in person.

TOR E: Measures taken by other Australian and international jurisdictions to mitigate transfer of care delays and its effects;

Telehealth systems are a valuable tool for increasing accessibility to healthcare across Tasmania and in other jurisdictions across Australia. However, virtual care may or may not be adequate/appropriate in all circumstances. The current administrative arrangements for public outpatients are complex, hard for patients to navigate, and largely in-hours.

Virtual care, including telehealth by phone or video and remote monitoring for symptomatic change, brings the potential for physicians and other health professionals to provide more care to more patients and reduce hospital presentations.

Telephone-based specialist consultations are needed, including for complex conditions, are available, particularly for rural, regional and remote patients with geographical barriers to specialty medical access, as well as priority communities with lower incomes, which also have a higher incidence of chronic diseases needing specialist input.

In other jurisdictions such as NSW, innovative remote monitoring projects enable real time data to be leveraged in the responsive care of patients with type 2 diabetes and chronic obstructive pulmonary disorder (COPD). These could serve as templates for Tasmania in its development and expansion of the virtual care infrastructure.

Virtual care options are essential to the success of Hospital in the Home (HiTH) in Tasmania. As we highlighted in a 2021 submission to the then Independent Hospital Pricing Authority (IHPA), HiTH has been shown to reduce acute and subacute bed utilisation for conditions such as cellulitis, pneumonia and COPD. Appropriate funding mechanisms focused on creating the technological settings required for interoperability between professionals, and between professionals and patients, are needed to realise the benefits of HiTH.

Recommendations:

- Ensure telephone-based specialist consultations are available, particularly for rural, regional and remote patients as well as priority communities.
- Invest in trialling new models of telehealth and remote service delivery linking secondary and primary care settings, including telehealth hubs in rural, regional and remote areas.
- Fund videoconferencing technology packages to building patient capacity and promote equitable access to telehealth, including in rural and regional areas, aged care settings and for patients with a disability.
- Develop a funding model and mechanisms for health professionals to enable equitable access to health technologies.
- Expand HiTH services, including geriatric evaluation and management in the home, across the state.

TOR F: Further actions that can be taken by the State Government in the short, medium, and long term to address the causes and effects of transfer of care delays

Additional funding for public hospitals is needed

Our 2023 submission to the Independent Hospitals and Aged Care Pricing Authority (IHACPA) on the pricing of public hospital services outlined that factors such as substance use, homelessness, mental health and both physical and intellectual disability are additional significant cost drivers that should be considered in pricing and funding hospital services. Complex needs, often presenting across the lifespan, require more intensive resourcing for appropriate hospital care, including higher staff-to-patient ratios, longer consultations, additional specialist to GP coordination, adjustments to facilitate support staff where applicable, appropriate safety for support workers on site, and additional discharge arrangements.

The persisting silos between hospital care, social care, secondary and primary care systems create additional imposts for hospital physicians who need to negotiate and coordinate continuity of care for their patients. We have argued that the Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) pricing method used by the Commonwealth and states in pricing public hospital services must pay closer attention to the variability and complexity of care. For example, patients with intellectual disability present for outpatient and inpatient care with additional layers of complexity due to their disability and associated comorbidity profile. The requirements for disability support workers to provide adequate support and facilitate access and participation in health care

must be considered and accommodated across pricing approaches, including for sub-acute and non-acute services. Moreover, adults with intellectual disability are often frequent users of hospital services compared to peers without disability and they also experience high rates of preventable adverse events in hospital.

Additional time, care and disability support for presentation to hospital/hospital admission needs to be factored in public hospital pricing and applicable funding models. Frailty, complexity of need, and rurality must be considered specifically for the increased costs per person per episode of hospital admission, travel costs for ambulance services, and public hospital separations compared to metropolitan areas.

Well-resourced Urgent Care Clinics planned in collaboration with physicians may reduce pressure on hospital services

The RACP has welcomed the establishment of Urgent Care Clinics in NSW and Victoria, and we understand four Commonwealth-funded Medicare Urgent Care Clinics are planned for Tasmania (two in the south, one in the north and one in the north-west). Overseas experience shows Urgent Care Clinics can help relieve pressure on hospitals and support patients within community settings. To do so, the clinics must have access to a range of health professionals, including specialist physicians, for assessment and triage.[4] [5]

While Urgent Care Clinics are intended to address minor illnesses and injuries and are often intended to reduce pressure on hospital services, in practice, patients often present with complex issues requiring advanced coordination, especially in rural and remote areas.[6] Physicians support and enhance care management pathways that do not require hospitalisation. By including physicians in the planning and funding of the clinics, Urgent Care Clinics can best ensure the clinics improve access and relieve pressure on hospitals, becoming truly interconnected with the broader healthcare system and tailoring services to local area needs.[7]

More ambulatory multidisciplinary care clinics are needed in the community

There is a lack of multidisciplinary ambulatory care clinics including specialists within Tasmania. Alternatives to hospital based in-patient care within the community are needed for specific chronic conditions such as obesity and diabetes, where patients can access or continue to access hospital based and other specialties in a multidisciplinary setting. Increased investment in ambulatory care settings can improve capacity to support patients closer to their homes, workplaces and communities, before clinical needs are exacerbated and hospital care becomes required.

Innovative integrated models of care involving specialists are needed

The RACP has developed an integrated model of care for patients with cardiovascular multimorbidity and intermediate level care needs at risk of hospitalisation. Its intention is to breakdown the siloes that exist between Local Hospital Networks and Primary Health Care Networks, namely funding by two separate levels of government and the continuing limitations of the 'fee-for-service' model of care, which sees patients referred and re-referred to practitioners working in isolation for 'single occasions of service', often with delays, poorer coordination and integration.

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[4] Access to specialist physicians must be included in establishment of urgent care clinics in NSW and VIC [Internet]. The Royal Australasian College of Physicians; 2022 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/news-and-events/media-releases/access-to-specialist-physicians-must-be-included-in-establishment-of-urgent-care-clinics-in-nsw-and-vic

[5] No choice but to face the crisis – RACP says Federal Budget must invest in healthcare system [Internet]. The Royal Australasian College of Physicians; 2022 [cited 2023 Sep 27]. Available from: https://www.racp.edu.au/news-and-events/media-releases/no-choice-but-to-face-the-crisis-racp-says-federal-budget-must-invest-in-healthcare-system

[6] Victorian Department of Health and Human Services. Urgent care centres: Models of care toolkit [Internet]. 2017 Aug [cited 2023 Sep 27]. Available from: https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/u/ucc-models-care-toolkit.pdf

[7] Prime Minister of Australia. Media Statement - Meeting of National Cabinet [Internet]. www.pm.gov.au. 2022 [cited 2023 Sep 27]. Available from: https://www.pm.gov.au/media/national-cabinet-2022-12-09

The RACP model of care is based on blended or value-based funding to support practitioners, especially specialists and GPs to work more seamlessly and responsively in the direct and indirect aspects of patient care to improve their outcomes. The model, which interlinks both private (GP and community physician services) and public services (admitted and non-admitted hospital services), would offer the following benefits: reduced wait time costs; reduced costs of delayed and deferred care for the Tasmanian health system through increased proactive physician input to patient care; more efficient planning and agreement of chronic illness supports for coordinated management by providers; reduced variability of care and increased continuity of care.

We would welcome further engagement on our model of care and its benefits for Tasmanian patients.

Investing in the expansion of the Tasmanian specialist healthcare workforce

Any new service requiring specialist care, and many measures likely to be recommended by this Inquiry, will face workforce recruitment and retention challenges, which are a severe brake on the Tasmanian health system's current ability to deliver world class care in equitable ways across the state.

This is a problem well beyond the hospital system. Fellows from our Paediatric and Child Health Division report that waiting times for some community child health services (e.g., assessment of developmental delay disorder) can be longer than the age of the child.

As identified in our 2021 Tasmanian Election Statement, high quality and local training of junior doctors, including physician trainees, is crucial to ensuring the availability of a capable specialist workforce to meet current and future healthcare needs. Workforce limitations stretch existing services and cause inequities across the state key areas such as child health, occupational health and chronic illness. They also contribute to low job satisfaction/morale, including by the perception of pressure not to let down one's patient's and colleagues by taking appropriate and necessary leave.

It is important for the Select Committee to be cognisant of, support, and value the contribution made by physicians to training junior doctors within the Tasmanian health system. Direct clinical care is the ultimate role of most physicians, but their duties to that end include indispensable activities such as supervision, research, mentoring, and management.

The Inquiry should acknowledge that these activities constitute an essential investment in Tasmania's future specialist workforce, including in specialties with relatively few practitioners in the state. While the RACP does not advocate on industrial matters such as remuneration, Tasmanian physicians and trainees report colleagues leaving the state due to a lack of funded positions, poor job security, and poor pay compared with other states. Most junior doctors are required to apply yearly for positions, so offering longer contracts could assist in staff retention, even absent other measures to boost retention.

We also refer you to page 4 of our Election Statement for additional commentary on workforce attraction/retention that may be useful to the Committee.

Recommendations:

- Ensure additional time, care and disability support for presentation to hospital/hospital admission is factored in public hospital pricing and funding models.
- Establish Urgent Care Clinics in Tasmania that are well resourced and planned in collaboration with physicians to reduce pressure on hospital services:
    - Coordinate with the Commonwealth Government to ensure a model of care that works for Tasmania, with long-term/sustainable funding.
    - Involve RACP members in planning clinical assessment, treatment, and triage protocols within Urgent Care Clinics.

    - Fund independent studies with priority populations to determine the number and location of Urgent Care Clinics needed in rural, regional, remote and metropolitan areas to reduce hospital admissions safely and effectively.
- Increase ambulatory multidisciplinary care clinics in the community:
    - Invest in expanded multidisciplinary ambulatory care services, integrated care services and outreach programs to ensure timely provision of complex whole-person care including direct engagement of specialist care. We also note that working in a well-resourced, well-run community care environment is a drawcard for many clinicians across the spectrum of practice locations and is therefore a key workforce recruitment/retention mechanism in itself.
    - Invest in bulk billed specialty medical clinics for specialties underrepresented in publicly funded clinics, to reduce pressure on hospitals and provide responsive care.
    - Adequately fund qualified palliative medicine, geriatric medicine and other physicians and advanced trainees in ambulatory and community settings (including residential aged care facilities).
- Deliver innovative integrated models of care involving specialists with proof of-concept sites for the management of patients with comorbid chronic health conditions and associated disabilities (see RACP Model of Chronic Care Management).
- Expand the Tasmanian specialist healthcare workforce
    - Commit to funding training places commensurate to population size and distribution.
    - Recognise that the training of physicians is an integral part of the delivery of healthcare services and commit to services having suitable physical resources and sufficient protected time for teaching, supervision, and research.
    - Continue to work with the Commonwealth and other states and territories in undertaking workforce planning.
    - Ensure that any new directions in clinical workforce are only developed and implemented with appropriate consultation and leadership from physicians and the RACP.
    - Develop and implement specific attraction/retention strategies for specialties with unique characteristics, such as Occupational and Environmental medicine and Public Health medicine.

TOR G: Other related matters

Increase investment in preventative health measures

The RACP is committed to improving the health of communities and addressing the inequities that underpin poor health outcomes. Across Australia all jurisdictions have dedicated significant resourcing toward addressing the symptoms of disease rather than reducing the root causes, contributors and influences that give rise to disease. Ten largely preventable chronic diseases are driving a high proportion of hospitalisations and an even higher proportion of deaths nationally.[8]

The National Preventive Health Strategy (2021-2030), to which Tasmania is a signatory, commits the Australian Government, state and territory jurisdictions to allocate 5% of total health expenditure to preventive health by 2030. Preventive health initiatives listed in the Strategy include disease surveillance and monitoring, preparedness planning, increasing cancer screening and prevention, growing information and health literacy, reducing tobacco, nicotine and alcohol use, promotion of healthy dietary consumption, and regulations to reduce the harmful effects of unhealthy diets and their advertising.

[8] AIHW, Chronic conditions and multimorbidity [internet]. June 2023 [cited Oct 3]. Available from: Chronic conditions and multimorbidity - Australian Institute of Health and Welfare (aihw.gov.au)

A whole-of-government approach is needed to address chronic disease and improve health, including addressing the social determinants of health. The Tasmanian Government should act on prevention as a matter of urgency. Any gains made by investment in preventive initiatives, for example, hospital cost savings, would open further funding for reinvestment in state programs and community health.

Recommendations:
The Tasmanian Government should:

- Go beyond its in-principle commitment to spend 5% of health expenditure on prevention by 2030 and specify how prevention will be funded over forward estimates under the auspices of the National Preventive Health Strategy
- Implement whole of government action to address chronic disease and the social determinants of health.