AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
ABN 91 028 693 268

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A/Executive Coordinator
to the Deputy Chief Executive, Commissioning and Performance
Department for Health and Wellbeing
Government of South Australia

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Dear Ms Harrison

Re: Statewide Demand and Escalation Policy 2021

Thank you for the opportunity to provide feedback on the updated policy to manage emergency health service demand in South Australian hospitals. The Australian Medical Association in South Australia (AMA(SA)) notes the need for collaboration among service providers to prevent the overcrowding and delays in treatment during periods of extraordinary demand for hospital beds. However, our members contend that this policy document offers no substantive measure to address the fundamental problems that cause overcrowding and delays in our hospital and ambulance systems. As the peak professional body for doctors in South Australia, the AMA(SA) is well informed about the issues facing our public hospitals and advocates for a health system that puts people at the centre of decisions.

We have sought and received input from specialist medical practitioners in both public and private sectors, doctors in training and medical students – all currently impacted by the current state of surge demand within the public *and* private health sectors.

We note and recognize the inter-relationship between the demand for various elements of acute and urgent care (mental health, emergency surgery and acute medical presentations) and elective, planned care resulting in competition for bed capacity in our major hospitals.

We also note that delivery of care in an escalation phase of demand can only be matched by adequate resourcing. Re-design of models of care to minimize reliance of acute hospital care (in-patient stay) requires significant support of community-based health care – again, requiring appropriate resourcing and a reduction of red tape to ensure responsive service. As we have noted for some years, there needs to be better coordination/ incentivization of general practitioners and visiting nursing services to support discharged patients. Whilst outsourcing of care may provide an option for management of surge demand, the AMA strongly advocates for maintenance of standards, training opportunity and clear governance models to manage this process.

Another aspect is a lack of available imaging and lab services which causes overnight delays and ultimately congests the system. With digital technology a central radiologist

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could report for several emergency departments (EDs) after hours as they do in some private hospitals and the only onsite cost is the radiographer.

Principles

We broadly support the principles outlined in the policy and the aim noted here and in the Ambulance Distribution for Demand Management Policy Directive to act early to avoid a crisis in-patient admissions. If ED overcrowding and ambulance ramping were an extraordinary event, this systems-wide approach to trading bed capacity across Local Health Networks (LHNs) may be of some use. However, given that overcrowding and delays are endemic so as to have unfortunately become "Business As Usual" (BAU) for hospital staff, more substantive efforts are needed to redress the root causes of the crisis.[1] Cancelling teaching, training/meetings and elective surgery to manage demand should be a last resort, rather than a regular occurrence, as these have significant implications for medical training, clinical governance, patient safety[2] and system sustainability[3]. Specialist Colleges and specialist training boards require certain activities to be maintained in our public hospitals to meet codified standards to maintain training posts. These have been challenged by the pandemic but any sustained deviation of training and research activities due to redeployment during periods of sustained surge activity puts at risk training posts in our major hospitals and, consequently, the future medical workforce for South Australia.

Governance and Accountability

Our members note that this systems-wide approach to demand dilutes accountability for managing resources effectively. LHN Boards are responsible for the governance and oversight of local service delivery in their area and ensuring they manage resources effectively to meet service demands. This local management structure is also intended to support the goal to treat patients as close to home as possible as it is widely understood that this produces the best outcomes for patients and families. Our members note that the systems-wide approach undermines this management structure. If the governance structure is to be genuinely implemented, the Policy Principles should state that each LHN is responsible for the efficient and effective management of resources to reduce waiting times for patients. LHNs should be able to call on collaboration from other LHNs to support system flow in exceptional circumstances, not daily.

The designation of the Royal Adelaide Hospital as the state COVID-19 hospital creates particular pressures for Central Adelaide Local Health Network (CALHN) which is also the state's major trauma centre and provides many of the state's quaternary and multidisciplinary based care for complex non-trauma patients.

Ramping and diversion of patients unfairly penalises hospitals that make a constructive effort to manage their demand and disadvantages patients who cannot be treated close to home. The ability to transfer patients to other LHNs when waiting times escalate obfuscates accountability for ongoing or recurrent bed shortages. Our members have also detailed the impact of delayed delivery of treatment to patient outcomes. They note that SA Health must share accountability for reducing overcrowding and ramping and this is not adequately

[1] Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L (2018) Emergency department crowding: A systematic review of causes, consequences and solutions.
[2] Cowan, R.M., Trzeciak, S. Clinical review: Emergency department overcrowding and the potential impact on the critically ill. *Crit Care* **9,** 291 (2004).
[3] Access Block – Position Statement Australian College of Emergency Medicine https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx

captured in the policy. Accountability falls to the LHNs (in particular CALHN) to manage system pressures and to divert resources to redirecting patients to other LHNs which are often under similar bed pressures. The Mandatory Demand Management Strategies outlined in Section 3 Table 1 call for collaboration to ensure patients are accommodated and receive timely care but it is unclear who is responsible for securing this collaboration should there be a dispute about bed availability.

There is a perception that the system is forced to provide additional bed capacity for the chronically squeezed Royal Adelaide Hospital so as to reduce public scrutiny of its problems. Equally, where there is discussion about monitoring for delays it is unclear who is responsible for such monitoring. While the lead indicators outlined in Attachment 1 Table 4 are to be reviewed regularly it is not clear how this will be done or by whom.

Underlying Causal Issues

Our members are concerned that the whole-of-system approach masks the specific bottlenecks and capacity issues in LHNs and underlying problems at different hospitals – for example, inadequate mental health beds for patients at the Royal Adelaide Hospital, bottle necks with aged care transfers at Flinders and an inadequate number of beds at the Lyell McEwin hospital.

The strategies and actions outlined in Section 3 Table 1 have already been used for some time and have achieved no improvement in ED overcrowding and ramping. For example, Section 3 Table 2 notes the need to decant patients to peri-urban hospitals when metropolitan ED status is greater than 100 per cent, yet metropolitan hospitals are consistently operating at this capacity. The transfer of patients to peri-urban hospitals, whilst theoretically a pathway to decompress their center, is often resource intensive and can only occur when appropriate medical care can be safety provided at the destination peri-urban facility. Moving patients to peri-urban hospitals is not the patient-centred approach prescribed by the National Safety and Quality Health Service (NSQHS) standards. Furthermore, this strategy is usually merely a revolving door with patients returning swiftly to the metropolitan EDs (as reflected in readmission rates currently not reported). Long stays in the ED are now the rule, not the exception, for admitted patients and also for some who are not admitted, and the escalation measures outlined in Attachment 5 are already in place. The AMA(SA) is advised that they fail on a daily basis as the resolution takes more than 24 hours to put into effect. It should be noted that the sustained systemic pressures outlined in the teleconference process in Attachment 7 are occurring almost continually. Effective decompression of the system using the teleconference process has not been demonstrated as evidenced by the regular SA Health statewide Code Yellows.

Process Re-engineering

The main cause of ED overcrowding and ambulance ramping is the ED Access block where admitted patients cannot move from the ED to a ward bed within eight hours. Therefore, the policy should focus on preventing this block and improving flow to inpatient wards. Overwhelming feedback from our members has been that the policy should focus more clearly on inpatient flow as well as the flow from the acute system to subacute and supported discharge destinations. It has also been noted that hospitals require a nightly bed vacancy of between 5 per cent and 15 per cent in order to accommodate the demand that will inevitably occur over the night shift. This is not possible if discharge blocks are not resolved with the impact on elective care – surgical and non-procedural – leading to wait list pressures that the LHNs have had to devote resources to achieve. Our members remain resolved to work within a system that does not work, using principles of rationing of care,

clinical decision making based on available resourcing or changing the indications of intervention anticipating likely delays.

We have provided specific feedback on the policy document in **Attachment 1**.

These include the following issues:

- Reporting on identified delays in the patient journey
- Maximizing Direct Admissions Pathways and transit lounges for clinically stable patients to avoid ED admissions
- Strategies for ED to Ward Transfers
- Elective surgery scheduling to stabilise demand
- Inpatient management to be divided into acute and subacute inpatient streams and transfer from acute to subacute beds identified as a critical issue. Solving this would be the most significant single action to help capacity management.
- Management of flows to ED to ensure inpatient senior decision makers are on site during the weekend to facilitate timely discharges.
- Patient discharge metrics
- Options to increase capability and support at regional LHNs to minimise potentially avoidable transfers
- Ambulance transfers and ED wait times
- Hospital Response Matrix.

In summary

South Australian hospitals cannot continue to operate in an environment where overcrowding and ambulance ramping is a daily event and where there is an expectation that they will perform poorly against national benchmarks. We should instead aim to achieve – indeed exceed - best practice standards for high quality, timely treatment. This requires process re-engineering rather than a policy that fails to address the underlying issues causing the recurring and distressing delays for emergency and mental health patients in our hospitals.

Please contact me at any time if you wish to discuss any of the issues raised in this letter by contacting Mrs Claudia Baccanello on 8361 0109.

Yours sincerely

Dr Michelle Atchison
President AMA(SA)

Attachment 1

Section 5. Policy requirements

Inclusion of new paragraph to expand 2.1(d) in Appendix 1

- All LHNs are required to provide 6-monthly reporting to SA Health about identified delays to the patient journey, along with changes enacted to minimise these delays. Examples of metrics to identify common delay points include, but are not limited to
    - Request time to report on investigations (standard and advanced imaging, pacemaker interrogation, echo, laboratory and other)
    - Request to review time for allied health assessment
    - Patient ready for transfer to subacute care to discharge from acute care (inpatient rehab, RACF, NDIS, MH, other)
    - Time to Inpatient Consultant review from Admission
    - Time to OT for patients placed on emergency surgical lists
    - Number of patients discharged before 12pm
    - Time to ward bed from admission in ED
    - Percentage of patients receiving subspecialty consultation <12 hours when requested by inpatient teams.
    - Occupied bed hours by inpatients in ED and wards.

Appendix 1: Table 1

Changes to this table have been suggested below

ED Avoidance	• Maximise appropriate utilisation of ED avoidance initiatives including but not limited to: Priority Care Centres (PCCs), Hospital Avoidance and Discharge Support Services, Mental Health Co-Responder, Community Mental Health services, My Home Hospital, and the Urgent Mental Health Care Centre.

Suggest inclusion of additional strategy:

- Maximise use of Direct Admissions Pathways and transit lounges for clinically stable patients requiring admission from outpatient clinics and other health care facilities.

ED to Ward Transfers	• Maximise the use of ward 'pulling' of patients from ED, overseen by Nurse Unit Managers/Shift Coordinators and Flow Managers.

Include additional point:

- Ensure ward pulling is embedded in local site patient flow policy with metrics for review of this developed and audited.

Elective Surgery and Medical Cancellations	• Notify the Department when elective surgery requires cancellation. • Ensure that elective and medical (e.g. medical specialty, planned chemotherapy/oncology) admissions are only cancelled (on the day of or day before admission) in cases of lack of bed availability in accordance with this Policy. Any cancellations of elective surgery and medical cases must occur with consideration to urgency, clinical condition and coordination already undertaken.

Include:

- Ensure elective surgery lists are proactively planned around known times of system stress to smooth predictable demand, maximise effective use of bed stock across seven days and minimise patient disruption by cancellation of lists.

Inpatient	• Ensure long-stay patients are actively monitored via locally established reporting mechanisms. • Where there are delays and/or barriers to timely discharge or transition placement of long-stay patients, escalation must occur in accordance with the Management of Patients with Complex Needs Requiring Discharge or Transition Placement Policy Directive.

Comments:

- Divide into acute and subacute inpatient streams
- Suggest sites monitor blocks to admission to inpatient subacute care (e.g. inpatient rehab and GEM beds) with reporting on delays to access, as well as subacute LOS
- Transfer of patients to inpatient subacute beds identified as a hidden block in patient flow at some sites
- Transfer of patients out of acute beds to subacute beds more generally identified as a **critical issue** at all sites (subacute MH, NDIS, RACF etc). **Solving this would be the most significant action to help capacity management.**

Patients in ED	• Work collaboratively to ensure all patients in an ED awaiting placement are accommodated and receive timely care and access to inpatient capacity. • Optimise weekend flows by ensuring senior decision makers are on site to facilitate timely discharges when sites are experiencing capacity issues.

Replace second point with:

- Optimise weekend flows by ensuring *inpatient* senior decision makers are on site to facilitate timely discharges
- Delete reference to “when sites are experiencing capacity issues” – this should be usual business / standard practice).

Patient Discharge	• Maximise daily discharges including the use of Criteria Led Discharge pathways and discharge facilities (e.g. discharge lounges).

Include:

- Maximise and review as a performance indicator, number of discharges prior to 12pm daily.

Repatriation of patients awaiting subacute services	• Where patients are delayed in one LHN while awaiting subacute services in an alternate LHN, sites must explore repatriating the patient to the site where care will be received within 24-48 hours of notification from transferring LHN.

Comment:

- Worth including a comment about avoiding 'double handling' – no point in transferring between acute beds if subacute bed available next day.

Utilisation of Regional Sites	• Maximise utilisation of regional sites where clinically appropriate and when capacity is available.

Include:

- Explore options to increase capability and support at regional LHNs to minimise potentially avoidable transfers. These might include expanded use of telemedicine, expanded access to diagnostics and metro to regional support in line with LHN Service Level Agreements.

Appendix 1: Table 2 Comments

Delays in Ambulance Transfer of Care	• Where there are delays in ambulance transfer of care greater than 30 minutes, the Ambulance Transfer of Care Escalation Process in Attachment 4 will be initiated. • Where appropriate, ED clinicians should inform hospital management of the risk to patient care and the requirement to restore a safe working environment.

Reword second point to read:

- Where clinical concerns exist, senior ED clinicians should inform hospital management of risk to patient safety and the organisation's requirement to restore a safe clinical and working environment including through the activation of agreed internal escalation codes such as Code Yellow

ED Wait Times	• When a patient requiring admission has been waiting for eight (8) or more hours in the ED (from time of arrival at ED), the escalation process specified in Attachment 5 must be enacted. For forensic patients, refer to Attachment 6. • Delays in ED greater than 24 hours must be reported as an incident in the Safety Learning System (SLS).

Amend second point to read:

- Delays in ED greater than 24 hours must be reported as an incident in the Safety Learning System (SLS) *and are the responsibility of the unit to which that patient is admitted*

Appendix 1: Table 4 Comments

Hospital Response	• Assess workforce requirements, and the need to cancel non-urgent training/meetings. • Initiate elective surgery cancellations and postponements. • Assess demand and capacity in Burns and ICU (Adult and Paediatrics), if required. • Review and consider the need for aged care capacity and establishing contact with the Commonwealth for potential patient transfers. • Review the need to purchase specialty bed capacity, including Transitional Care Packages, Care Awaiting Placement beds, or private capacity, and establish contact for potential patient transfers (the Department on behalf of LHNs). • Suspend outpatient and ambulatory services as required. • Negotiate temporary extension of PCC operating hours, and operating hours of other community services where possible. • Provide support in the SAAS Emergency Operations Centre (EOC) to assist in utilisation of alternative services, particularly PCCs. • Review statewide Mental Health demand and capacity, ensuring adequate support to patients in ED. Where required, initiate integrated management of mental health beds via the DHW Director of Mental Health Strategy as directed in the Mental Health Bed Management Direction. • Alert mental health community teams, SAAS and CALHNs Mental Health Co-Response to establish out of hours/weekend support as needed.

Comments

Dot Point 1 Cancellation of training:

- To be avoided in all but the most exceptional circumstances. Where cancellation of training occurs, ACEM (and potentially other College) training accreditation requirements may be breached, placing accreditation for Specialist training at risk

Dot Points 4 and 5 Aged care and subacute bed stock:

- Access to aged care capacity, TCP, CAP beds, NDIS and all subacute beds needs to be a massive focus of the organisation every day – not just as a response to State Alert.
- SA Health needs to explore ways of working with the federal government to address subacute capacity as quickly as possible.
- Subacute bed stock also needs to be closely managed – we cannot afford to tolerate any bed vacancy in this area as the system stands currently.

Point 7: PCC

- ED overcrowding is a function of inpatient access block and patients requiring acute care. Extending the hours of the PCC will be a costly and ineffective measure in attempting to offset system pressure during State Alerts.

Attachment 1: Escalation Trigger Matrix and Action Plan Template

Escalation Level	Triggers	Actions
Green **Business as Usual**	Refer to page 9.	• Monitor operational position, ensuring early assessment within identified triage category time period. • Monitor incoming SAAS arrivals. • Monitor for delays in clinical decision making (including inpatient team reviews within 60 minutes of referral). • Focus on use of hospital substitution and community home support programs. • Wards to actively pull admitted patients from ED. • Triage Nurse to suggest General Practitioner (GP) consults and other primary care facilities (e.g. PCC) for minor cases. • Patients identified for discharge to be taken to discharge lounges or appropriate area.
Amber **Standard Escalation Level 1**	Refer to page 9.	Undertake all preceding strategies and actions **plus**: • Consider alternatives for admission to hospital where clinically appropriate. • Ensure ambulant patients awaiting tests/results are streamed to waiting room. • Relocate staff from low to high activity areas. • Identify any blocks to care and/or flow, contact relevant service to expedite correction (e.g. Radiology, Inpatient Review, Laboratory, Allied Health and Patient Transport). • Any patients awaiting discharge transport in-hours to be assessed for suitability for "fit to sit" or to be placed in waiting room or transit lounge. • Notify Medical, Surgery and/or Specialty teams to aid admissions process. • Where inpatient reviews are significantly delayed, relevant inpatient service to enact service escalation plan and notify COO. • Rapid senior round / review of all patients (ED and inpatient wards).
Red **Standard Escalation Level 2**	Refer to page 9.	Undertake all preceding strategies and actions **plus**: • Open and staff flex and surge capacity • Transfer of non-aligned patients to peri-urban country hospitals. • Activate bed management meeting to review elective activity and assess requirement to defer category 2 & 3 surgical overnight stay patients. • Review private patients for transfer opportunities.
White **Standard Escalation Level 3**	Refer to page 9.	Undertake all preceding strategies and actions **plus**: • Pharmacy / Medical Imaging / Allied Health / Pathology to postpone non-urgent activity and/or deploy additional staff to prioritise ED / Inpatient activity. • Open unconventional treatment spaces using workforce strategies. • Assess clinical appropriateness of patients for over-census use of wards. • Initiate deferral of category 2 & 3 surgical overnight stay patients. • Assess all non-urgent regional transfers to metropolitan sites. • Evaluate need to call-in extra nursing / medical staff to assist. • Purchase private capacity.

Comments

Many of the actions listed under Amber really belong under Green

- Consider alternatives to hospital admission where appropriate
- Ensure ambulant patients streamed to waiting room
- Identify any blocks to care and / or flow and contact relevant service to expedite correction
- This should also include explicit reference to whole-of hospital scope i.e. it is essential to understand and remediate blocks to inpatient flow.

Modify

In Green actions, change from

- Monitor for delays in clinical decision making (including inpatient team reviews within 60 minutes of referral)
  To
- *Bedside nurses, flow nurse and medical staff* to monitor for delays in clinical decision making (including inpatient team reviews within 60 minutes of referral) *and contact*

inpatient teams to escalate.

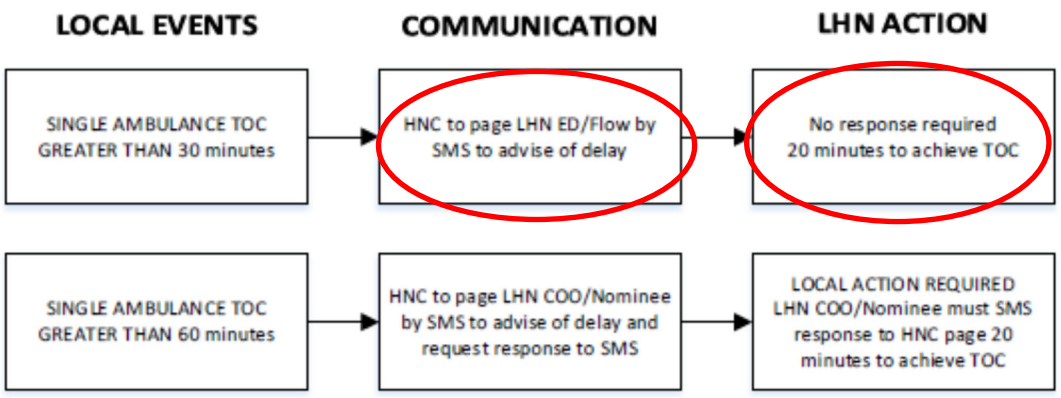
In Amber actions, change from

- where inpatient reviews are significantly delayed, relevant inpatient service to enact service escalation plan and notify COO"
  To
- where inpatient reviews delayed > 2 hours from referral, relevant inpatient service to enact service escalation plan and notify COO.

In Amber actions, add

- SAAS to review patients awaiting transfer from acute beds to RACF / subacute facilities and expedite where possible to free up acute bed capacity (and in turn allow TOC).

Attachment 4: Transfer of Care (TOC) / Event Escalation process 07:00 – 24:00



Comments

- HNC contact to is ED not necessary and unhelpful. ED will be clearly aware they are ramping ambulances and will be actively trying to do what they can – notification of hospital executive and hospital flow may be of some use – but we need to avoid interruptions to clinicians trying to work in what will be a very busy time.

- 20-minute timeframe for LHN response should be changed to 30 minutes to align with escalation on next line (which occurs at 60 minutes, not 50 minutes)