AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
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The Hon. Peter Malinauskas
Minister for Health
Level 9, 11 Hindmarsh Square
Adelaide SA 5000

Email: healthministerforhealth@sa.gov.au

Dear Minister

Future Service Model for Modbury Hospital

Thank you for the opportunity to express our members' views on how services at the Modbury Hospital (MH) can be improved. The Australian Medical Association (SA) (AMA(SA)) has consulted extensively about the most appropriate mix of service delivery at the hospital to serve the north eastern community. Please find attached an explanation of the proposed solution, a table of options to support expanded surgical and medical case mix.

The problem with the current service configuration at Modbury Hospital for patients

In theory, under Transforming Health, the north eastern community should be able to access acute services and emergency surgery at the Lyell McEwin Hospital (LMH) and receive emergency care, 24-hour-stay elective surgery and low acuity care at Modbury Hospital. In reality, members of the community are frequently unable to access appropriate care when they need it. This is primarily due to the LMH being unable to meet service demands leading to bed block and slow/poor transfer times. This highlights the fact that MH emergency department and surgery teams do not have sufficient acute short term support.

While those supporting the Transforming Health 3-spine hospital model emphasise that the LMH hospital is only 15 minutes away from the MH, the reality for many local people is that it is extraordinarily difficult to access. The Lyell McEwin Hospital is stretched to its limit, as are ambulance services, and many of the 250 patients/month transferred on average from the MH to the LMH have to wait in uncomfortable conditions for extended periods. The MH has a much higher transfer rate than other Adelaide hospitals and longer patient waiting times. Elderly patients particularly struggle to be seen – as they do in all public and private hospitals under the current model. In addition, many families including elderly and infirm find it almost impossible to access via public transport to visit loved ones as it can take an average of two hours travel time due to the transport routes/corridors and schedules.

Training and professional development challenges

At the same time, doctors at the hospital have lost access to appropriate case mix to enable them to maintain skills in key areas (for example the hospital has dropped from three to one surgical trainee), and training places in surgery and anaesthetics have been lost, despite a recognition that the Modbury Hospital has provided excellent training.

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Proposed solutions – in summary

Significant investment in capital and recurrent funding is needed to support better localised care for the community at MH – not a duplication of services at the LMH but a better use of available skills and resources to support the Northern Area Local Health Network (NALHN).

A discussion of the solutions is provided at Appendix 1 but in summary, the most efficient and effective approach to addressing the problems at the MH would be to:

1. **Increase the number of Intensive Care Beds for NALHN** from 14 to at least 20 at the LMH
2. **Improve the patient transfer system** –A clinical transfer unit supported by better access to beds and ambulances is desperately needed to ensure safe rapid transfer of patients to appropriate care. This would alleviate the need for doctors to spend extended periods bargaining over beds, reduce the need for 'higher care' at MH whilst awaiting transfer and greatly alleviate clinical stress and diversion of clinical resources in ED to keep patients stable.

   The reliance on ambulance availability, bed availability and acceptance of patients has led to significant delays, stress and resource diversion in the ED at MH. Previously the AMA(SA) has raised the possible need for a dedicated NALHN managed shuttle service for some patients suitable for this type of transport. Whilst this seems 'out of the ordinary' it has been mentioned several times over the past few years and somehow the transport issues between the 2 sites requires attention.

3. **Enable a more complex surgical case-mix at MH** – Increase the scope of surgical services to enable low risk elective and emergency surgery (up to 72 hour stay) to reduce wait-times for patients, reduce demand at the LMH, and to improve the case mix for continuing professional development and training for surgical and anaesthetic staff. Elective surgery such as ventral hernia repair; shoulder replacement and hysterectomy in patients without significant comorbidity would be safely provided. Also a clearly defined policy allowing surgeons and anaesthetists flexibility to provide immediate or delayed acute surgery in selected cases must be available. This will also increase community and clinicians satisfaction with clinical services being provided locally.
4. **Create additional acute medical beds** – Provide additional acute medical beds (with funding for appropriate staff) to meet demand, particularly from the growing ageing local population and to support the focus on geriatric care at Modbury.
5. **Implement an appropriate clinical governance model and appropriate management for MH services**– Implement a clinical governance model to ensure patients selected for surgery or medical treatment at the MH are low risk (with limited co-morbidity etc). A management model is also required to ensure clinicians at both the LMH and MH are equally involved in decisions about their services.
6. **Create an extended Recovery Unit/Higher Observation Unit** – Establish a unit with a high ratio of nursing staff (2:1) and some physiological monitoring to support the change in surgical case mix. Surgeons and physicians would be responsible for their own patients in the unit. LMH could support a perioperative support model without the need for a high dependency unit.
7. **Restructure the training network in collaboration with professional colleges –** Colleges currently require site-based accreditation which does not fit the networked hospital system. We need clinicians with representatives of LMH and MH and colleges to develop an excellent training network across sites.
8. **Develop purpose-built palliative care facilities for NALHN –** Building on the current investment in sub-acute aged care, it is reasonable to invest in a purpose built 16 bed palliative care facility on the Modbury site.
9. **Improve inpatient geriatric facilities** – Provide capital investment to improve inpatient geriatric services to meet growing demand and provide a level of care comparable to

that available in the Southern Area Local Health Network. This is needed to divert pressure on the emergency department and reduce the number of transfers.

10. **Improve acute mental health facilities (Woodleigh House)** – Provide investment for inpatient services for people with high mental health needs – this includes acute care for psychiatric patients and psychogeriatric services.
11. **Cardiology.**
    The services at LMH provide acute care. Modbury currently has a 2/52 outpatient clinic for general cardiology assessment and triage. What is needed is the necessary transfer capability and referral processes for management of acute care, assessment and management.

This approach would provide better local access to more services for the north eastern community, reduce pressure on the LMH and improve opportunities for continuing professional development and training – and hence recruitment and retention of medical and nursing staff.

Greater capacity is essential to provide appropriate services for the north eastern population and to remove pressure from the system which is currently simply failing to meet demand. The MH and its staff have the capacity to deliver additional safe care, particularly for more low complexity and lower acuity surgery, with some additional supports and appropriate structures in place.

We submit that by addressing the above, specifically, increased surgical services, including low risk acute/emergency surgery; much improved transfer between MH and LMH; peri-operative support and investment in a palliative care facility for the northern suburbs the hospital identity with the public and clinicians will be restored. There is also the importance of meeting the training and ongoing clinical professional development requirements to ensure that MH becomes a place where talented people want to work – as it used to be.

We would be pleased to discuss these options, risks and benefits in more detail if it is required.

Yours sincerely

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Appendix 1

Solutions explained

Intensive Care Beds

NALHN has 14 intensive care beds at the LMH which is insufficient to meet the demands of the region. The area has experienced a net loss of beds since Modbury Hospital's 6-bed ICU closed. This is not sufficient to cater for community need and consequently doctors often spend considerable time negotiating with other hospitals in the network for beds while patients wait for extended periods.

The area needs at least six more beds to meet demand and most believe the safest, most efficient and effective way of doing this is to add more beds to the LMH.

Patient Transfers

Modbury Hospital transfers around 250 patients a month across all specialties to the LMH.[1] It has the largest numbers of patient transfers in the Adelaide region and is the worst performing Adelaide hospital against National Emergency Access Target 4-hour Transfer target (NEAT). The lack of available beds and an over-stretched ambulance service means the north eastern community and the staff feel exposed to excessive risk.

A specialist clinical transfer unit should be responsible to make the transfer process safer and more effective but there also needs to be sufficient beds and ambulances to support the process. Another option is a dedicated transfer resource for NAHLN

Change in surgical case-mix at MH

The surgical unit has the capacity to do more complex surgery (2-3-day-stay) with some additional investment in an extended recovery unit. An innovative hybrid model of emergency surgery could be implemented. For example those needing a pin for a fracture might return home, fast and return for surgery the following morning or surgeons could be able to take suitable cases from the ED when the operating suite is available. This would alleviate pressure on the LMH, provide a more complex case mix for anaesthetists and surgeons to support their ongoing continuing professional development, and training opportunities for surgical and anaesthetic registrars.

Additional acute medical beds

NALHN does not have sufficient acute medical beds to support demand, particularly during the winter months and in the north east where the population is ageing. Additional acute medical beds would need to be supported by access to on-call senior clinicians overnight rather than the current staffing model which relies on junior staff and nursing. Additional acute beds would help to support the MH focus on geriatric care and reduce the need for transfers. The community expects to have access to these beds locally, particularly for elderly residents. Assessment for transfers to LMH and patient parameters suitable will need collaboration between sites.

An appropriate clinical governance model and management model for MH

Clinicians need to develop a governance model to define an appropriate service delivery model and patient profile to reduce risk. This would outline the types of procedures and cases that can be supported – for example ensuring that patients selected for surgery and medical admission at the MH are low risk (with limited co-morbidity etc). In addition a more effective

[1] LMH figures 010716-300617

collaborative management model is required to ensure clinicians at both the LMH and MH are equally involved in decisions about their services. Currently in several areas, clinicians who work infrequently at MH are responsible for its oversight. It makes sense to have those most affected by decisions at the MH involved in making them.

Extended Recovery Unit/higher observation unit

More complex surgery requires additional post-operative support through access to additional ICU beds at the LMH and an extended recovery unit at MH with a 1:2 ratio of nursing staff to patients and physiological monitoring (although no intubation). This would be supported by on-call access to 24-hour medical supervision. Under this model, surgeons or physicians would have responsibility for their own patients in the unit.

Restructured training network

Colleges currently require site-based accreditation which does not fit the networked hospital system. We need a clinical working group combining representatives of Adelaide hospitals and colleges to develop a training network across sites to provide excellent clinical training across the network of hospitals. This will help re-establish South Australia's reputation for high quality medical training, help to retain senior clinical staff and bright students in South Australia.

Purpose-built palliative care facilities for NALHN – NALHN's elderly do not have the same access to facilities as those in the south and the west of Adelaide which have purpose-build facilities. Investment is needed to provide the service the community expects.

Improved geriatric facilities

Inpatient facilities for geriatric patients at the MH are outdated and not fit for purpose. Not only are they located on the second floor of the hospital, patients are in 6-bay wards and required to share bathrooms. This does not meet community expectations.

Improved acute mental health facilities (Woodleigh House)

South Australia has insufficient inpatient facilities for people with acute mental health problems. Woodleigh House is in very poor repair and is not appropriate for patients with other medical problems. South Australia lacks a purpose-built facility for patients with high-needs patients, particularly since the closure of the Oakden facility. Managing psychiatric patients with high needs, including those whose brains have been affected by drugs and those with degenerative cognitive diseases, poses significant challenges for our health system. Capital investment in inpatient services and psychogeriatric services is needed.

Appendix 1

Options to support expanded surgical/medical case mix at the MH

Solution	Required resourcing	Benefits	Risks
Level 1 Intensive Care Unit at MH – 4-bed	Full team of intensivist medical and nursing staff 24/7 Support from medical specialists in hospital to ensure it is safe Significant capital investment Significant recurrent spending on trained staff	Supports expanded mix of surgical and medical cases More patients treated locally Potentially Reduces # transfers Increases opportunities for surgeons/anaesthetists/ physicians/trainees at MH to ↑case mix Reduced pressure on LMH/emergency department Community and some clinicians support	Inefficient (due to large fixed costs/small # patients) Poorer clinical outcomes in small units Unlikely to be accredited Possibly limited throughput due to changes in treatment approaches Possibly difficult to staff due to limited exposure to diverse cases
High Dependency Unit	Increased staff ratio IC oversight – not necessarily on site Capital investment in equipment eg ventilators and monitoring Recurrent spending on trained staff Medical beds with on-call access to senior staff	Supports some expansion in surgical and medical case mix More patients treated locally Potentially Reduces # transfers Some greater opportunities for surgeons/anaesthetists/physicians/ trainees at MH to ↑case mix Some reduced pressure on LMH/emergency department Some community support	Adverse patient outcomes Late transfer of patients = more dangerous Possibly limited throughput due to changes in treatment approaches Possibly difficult to staff due to limited exposure to diverse cases Limited clinical support
Expanded recovery unit	1:2 Nursing ratio to patient Capital investment – including in in physiological monitoring equipment Recurrent spending on trained staff Support from additional ICU beds at LMH and better transfer system 24-hour on-call support from senior staff Surgeons/physicians to monitor their own patients Clinical governance to ensure low risk procedures/patients Medical beds with on-call access to senior staff	Supports 2-3-day stay surgery and some emergency surgery More patients treated locally for selected surgical and medical Improved case mix for surgeons/anaesthetists/trainees/physicians Effectively uses skills/resources at MH Potentially reduces # transfers Additional ICU beds at LMH and transfer system reduces time for Some greater opportunities for surgeons/anaesthetists/ trainees at MH to ↑case mix Some reduced pressure on LMH/emergency department	Limited types of medical/surgical cases possible at MH Possibly difficult to select appropriate patients – over promises/under-delivers Community does not understand this option