

GMCT Report

Blacktown Mt Druitt Hospital Realignment of Services

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Introduction

Blacktown and Mt Druitt Hospitals have been administered as one hospital on two campuses for about 10 years. In January 2004 due to the difficulties in providing adequate intensivists cover, intensive care at Mt Druitt was changed from a Level 4 Intensive Care Unit to a Level 3 High Dependency Unit.

After discussions with Medical Staff, particularly the physicians providing acute general medical on-call, admission of acute medical patients to Mt Druitt ceased in October 2004. Phase 1 of the clinical services realignment plan included in-patient Paediatrics being concentrated at Mt Druitt and development of rehabilitation and palliative care services also at Mt Druitt.

At the request of Professor Steven Boyages, Professor Kerry Goulston and Dr Grahame Robards of the General Metropolitan Clinical Taskforce were asked:

1. To provide an assessment and evaluation to the Administrator on the implementation of the Blacktown Mt Druitt Hospital (BMDH) clinical services realignment plan, Phase 1.
2. To advise on any changes needed in Phase 1 of the clinical services realignment plan
3. To review the BMDH clinical services realignment plan, Phase 2 and to recommend amendments as needed.
4. To provide comment on the strategies that are being implemented to address the concerns that have been raised by staff and community members.

Methods

A review of correspondence and reports produced during 2004 was conducted and interviews were held with senior clinical staff, managers and health planners of Blacktown, Mt Druitt and Westmead Hospitals between 21 December 2004 and January 14, 2005. Interviews were also held with volunteers and community members at Mt Druitt, Managers of Allied Health at Blacktown/Mt Druitt, Transport Officers for Western Health, Emergency Department specialists and a representative of the Australian Medical Association. (Appendix 1)

Phase 1

Acute Medicine

Discussions with many physicians indicated that the transfer of all acute medical admissions to Blacktown has been very successful.

The changes to general medicine and sub-specialties have been beneficial allowing better Registrar cover thus improving efficiency and the standard of care. Patients were assessed more quickly and there was less discontent amongst Registrars and JMOs. There appeared to be improved supervision of JMOs and registrars and better "esprit de corps".

Aged Care/ Rehabilitation Medicine staff also believed that patient care had improved. Staff felt less harassed and they were pleased that new appointments were being made.

Clinicians felt strongly that the changes to general and sub-speciality medicine had benefited the whole Blacktown Mt Druitt community. They felt these services were now sustainable and provided an improved level of care.

Positive outcomes for Mt Druitt and Blacktown are demonstrated by a significant reduction in access block with the average length of stay and Orthopaedic waiting lists both having decreased.

Universal opinion amongst physicians was that consolidation of General Medicine to one campus was a much better arrangement allowing Registrars to see patients more often.

Cardiology

The Mt Druitt community is generally socially disadvantaged and has a significant incidence of heart disease.

Cardiology patients are at present being admitted to Mt Druitt Hospital, mainly through the Emergency Department. There is a Cardiology on-call roster and review of patients is conducted by Cardiologists and a Fellow in Cardiology. After-hours cover is by Resident Medical Officers and they are supported by the Senior Medical Officer in the Emergency Department. Occupancy varies at Mt Druitt between 6 and 12 beds.

The long term viability of a stand-alone Cardiology Ward was questioned by some non-cardiology senior physicians at Mt Druitt and they felt that consolidation to Blacktown would ultimately occur. A concern of Cardiologists was maintenance of the bed base for Cardiology. If the Cardiology Ward were to close at Mt Druitt and particularly if there was an alteration in the function of the Mt Druitt Emergency Department, the members of the Cardiology Department regarded an increase in capacity in the Emergency Department and in the number of Cardiology beds at Blacktown, to be essential.

This group considered that an alteration in the function of the Emergency Department at Mt Druitt would also adversely affect the provision of METs calls and that the provision of Cardiology in-patient beds at Mt Druitt would not be possible.

Clinicians expressed concern about timely access to angioplasty services at Westmead Hospital and we understand that this is currently being addressed.

Paediatrics

Paediatric inpatient beds for the two hospital campuses are now only provided at Mt Druitt Hospital. Senior Clinicians believe that this multi-disciplinary

Paediatric Ward is functioning very well. The reviewers concurred. Blacktown Mt Druitt Hospital employs 10 Paediatric Registrars. They provide a 24 hour service at both hospitals.

Admissions to Mt Druitt from Blacktown do not include high dependency paediatric patients who are transferred to The Children's Hospital at Westmead. These numbers are not large. A small bus is used to transport paediatric patients transferred from Blacktown to Mt Druitt.

Activity in the Mt Druitt Paediatric Ward is quite sustained. Discussion with nursing staff in the ward indicated that the work was very satisfying and the environment was pleasant.

Initiatives to increase paediatric community outreach services were welcomed by the staff and community.

Any change in the Mt Druitt Emergency Department should not affect paediatric care.

Aged Care/Rehabilitation/Palliative Care

The development of services was in progress at the time of the review visit and a Rehabilitation in-patient Ward was to be opened within days. Centralising services at Mt Druitt was considered by clinicians to be a positive move and to provide a "centre of excellence". Planning for a new Rehabilitation Centre is said to be progressing.

High Dependency Unit

The functioning of a single Intensive Care service comprising the Level 4 Intensive Care Unit at Blacktown and the Level 3 (High Dependency Unit) at Mt Druitt has been successful since its inception in March of 2004. The main activity was reported to be as an extended recovery ward for post-operative patients, especially after Orthopaedic surgery. If Mt Druitt Hospital

becomes a centre of excellence for elective surgery, then the Mt Druitt Level 3 HDU would provide a valuable support service.

Transport

The reviewers were impressed that a coordinated approach to visitor and patient transport between Western Area hospitals has been developed.

Visitor Transport

As part of Phase 1 of the BMDH clinical services realignment plan development of a Visitor Transport Service was undertaken following community consultations. This service commenced on 12th October 2004 under contract to a private Bus Company. A 35 seat, wheelchair accessible vehicle is used at the present time.

An interim evaluation report of the service has been produced covering the period between October and 23rd December 2004. This has shown that there is a clear demand for some form of visitor transport, that the demand is variable and that staff of the hospitals use the transport at times. The provision of visitor transport is essential, but the manner and the timetable of the service is to be reviewed.

Patient Transport

An analysis of patient transfers between Mt Druitt and Blacktown was conducted using the NSW Ambulance Service and HealthWest Transport data. It indicated that an average of 16 patients per week was transported. The transfers appear to be timely and effective.

Allied Health

Discussions were held with the managers of Allied Health departments who cover both campuses. There was universal concern about the impact of the changes in services for all disciplines. No additional allied health staff had been appointed at Blacktown to cover the increased workload related to the services transferred from Mt Druitt. At Mt Druitt, the increased focus on

rehabilitation and aged care has increased the workload for Allied Health staff on that campus. These workforce issues are being addressed.

Phase 2

Surgery

Planning for Surgery at Mt Druitt in phase 2 involves a proposal to concentrate on elective surgery. Complex surgery, surgery on patients with significant co-morbidities and weekend surgical emergencies would be performed at Blacktown Hospital.

The proposal for weekends would include no on-call roster for surgeons, anaesthetists or operating theatre staff at Mt Druitt. Emergency surgery would be performed at Mt Druitt on weekdays. Mt Druitt Surgeons and Anaesthetists have publicly expressed their concern about the planned withdrawal of emergency surgery at weekends.

A review of the number of patients undergoing emergency surgery at Mt Druitt revealed that on average there was only one case per weekend, of a predominantly minor surgical nature.

The High Dependency Unit's capacity to support increased elective surgery at Mt Druitt was questioned by some surgeons and anaesthetists.

Since the Mt Druitt ICU change, patients presenting with complex surgical emergencies have been transferred to Blacktown. A review of the time to theatre indicates that these patients reach Blacktown operating theatre in less time than had occurred previously at Mt Druitt waiting for admission to the operating theatre.

The plan for Mt Druitt not to provide emergency surgery or urgent elective surgery on weekends has been questioned by many clinicians, as has the lack of an acute surgical on-call roster. Operating theatre nurses face

decreased income if there is no weekend work or on-call. There will be a need for careful negotiation with theatre nurses about their changed working hours.

Surgeons strongly favour Mt Druitt Hospital becoming a centre of excellence offering 5 to 6 days per week elective surgery. The Area support this. The surgeons would be prepared to play a major role in communicating to the community the reasons for changes to services.

Elective surgery would involve provision of a Level 3 ICU/HDU, general surgery, orthopaedics, urology, dental, facio-maxillary and cataract surgery and other surgical disciplines as appropriate. It would require a 24 hour surgical on-call cover. Planned, predictable surgery with a major emphasis on day only surgery could serve a population beyond Blacktown Mt Druitt, including Nepean. It is understood that an excellent system for risk-identification and pre-anaesthetic assessment would be part of this.

The Surgeons themselves would be prepared to arrange a roster for elective surgical inpatients. Calls for surgeons on this roster would be infrequent. Concerns about the availability of physician consultations for elective surgical patients were expressed. Such calls would also be infrequent.

A fourth operating theatre should be commissioned.

Anaesthetics

There are 10 anaesthetists who work at Mt Druitt Hospital. Only one of them also works at Blacktown. There is no after-hours Registrar.

The anaesthetists at Mt Druitt have expressed their concerns about being drawn in to medico-legal issues when there is no anaesthetic Registrar in the hospital. The ability of medical personnel, out of hours, to always provide airways skills was also questioned. Anaesthetists will however provide a 24 hour 7 days per week on-call roster if there is also a surgeon's roster. Three anaesthetic SRMOs have been recruited to provide some airways capability but there are reservations of several clinicians that these Residents are often working unsupervised.

Emergency Department

Community representatives voiced their concerns about their ability to access hospitals at a greater distance than Mt Druitt.

Currently the Emergency Department at Mt Druitt Hospital has an Emergency specialist on-site from 0800 until 1700, Monday to Friday. At present there is one Staff Specialist FACEM (Fellow of the College of Emergency Medicine), one VMO FACEM and also one VMO FACEM on Saturdays during the day. After hours there is a CMO (Career Medical Officer), Registrar or Locum.

From midnight to 0800 there is a Locum. All Emergency Department Registrars are OTDs (Overseas Trained Doctors). There was some disquiet amongst physicians regarding medico-legal responsibility for acute medical patients during transfer to Blacktown Hospital. The clinicians and reviewers raised concerns regarding access to on-site Specialist/Registrar assessment.

It is of interest that if the ambulance bypass/diversion matrix had been implemented between Mt Druitt and Blacktown in 2003 there would have been 69 Triage 1 patients and 16 Triage 2 patients in that year.

Since October 2004 there have been on average 22 acute medical in-patient admissions per week transferred from Mt Druitt to Blacktown.

An acute medical admission from Mt Druitt to a ward bed in Blacktown now takes one and a half hours which is significantly shorter than previously. It is of note that access block has decreased from 22% to 11% from the Mt Druitt Emergency Department and from 42% to 22% at Blacktown Emergency Department. Similarly, the average length of stay for emergency admissions through Mt Druitt Emergency Department to Blacktown has decreased from 6 to 4 days.

A further significant gap in service provision is that there is no allocated Social Worker and the service is provided by Social Workers on a crisis roster.

Mt Druitt Emergency Department Presentations

2003

| Triage Category | Walk In | Ambulance |
|------------------------|----------------|------------------|
| 1 | 69 | 160 |
| 2 | 1048 | 735 |
| 3 | 6689 | 3474 |
| 4 | 9893 | 2219 |
| 5 | 1289 | 95 |

Comment

Whilst attempts have definitely been made to increase the medical staffing of Mt Druitt Emergency Department, it is far from optimal. Concern was expressed by many clinicians regarding patient safety. This mainly stems from the use of locums and relatively inexperienced medical officers for some of the out of hours and weekend shifts. Another issue of concern is the lack of supervision of RMOs and the lack of acute medical and surgical consultations.

There has been no reduction in senior medical staffing as part of the realignment process. However, concern was expressed by clinicians about the Mt Druitt Emergency Department as it is now operating. The reviewers concurred. A determination needs to be made, in view of ongoing workforce issues, about what clinical services the ED can and cannot offer.

There appear to be only two options:

1. The preferred option is that the Emergency Department should close.
2. Alternatively, the Emergency Department be replaced by an Acute Care Centre such as a "7/11", a new type of facility or a new model of operation, which might, depending on staffing, operate only between 0700 and 2300 daily.

Acute Care Centre

Either there would be no ambulances attending Mt Druitt Hospital or NSW Ambulance would employ a reverse Triage with only Triage 4 and 5 patients transported to Mt Druitt.

Between 0700 and 2300 there needs to be a senior staff member capable of diagnosing a sick patient, with relevant resuscitation and intubation skills. This should be a FACEM, Registrar equivalent or experienced CMO and would entail 14 shifts per week or 6 FTEs.

A comprehensive public education program would be necessary to detail the changing role of the Mt Druitt Emergency Department. Mt Druitt senior clinicians have indicated a willingness to lead this.

An emergency call button would need to be installed in a prominent place near the entrance to the facility for use between 2300 and 0700 and an ambulance would need to be on standby. Wards of the Hospital would need to be covered by an experienced CMO overnight who could attend to any emergencies presenting between 2300 and 0700.

Communication and the Community

Review of correspondence from community members and discussion at several meetings with community members revealed concerns about the future of Mt Druitt Hospital.

There is a lot of worry about communication, emergency surgery on weekends, the impact of negative media coverage and the function and staffing of the Mt Druitt Emergency Department.

Community members are strongly of the view that a 24 hour Emergency Department service must be maintained and that it must provide a full complement of emergency services. They also expect that the staff of the Emergency Department would all be locally based, suitably qualified and that no locums or General Practitioners will be used.

There is a large Aboriginal and Pacific Islander population in Mt DrUITT and the area is one of great social disadvantage. This leads to community concern about access to hospital facilities that are distant from Mt DrUITT.

Acknowledgment of the public fora concerning the planning of health services in the Area was made. However, the local community, and in particular the Aboriginal Community would like more discussions to be held. A major request was that the presentations be free from medical jargon and that explanations be comprehensive and reflect both short and long term plans.

The initial concept and instigation of Mt DrUITT Hospital came from the local Holy Family Community. They have held the previous fora and they believe that for meaningful communication, open meetings addressed by local clinicians should be held.

Conclusions and Recommendations

1. General and sub-specialty medicine

Implementation of elements of Phase 1 of the BMDH clinical services realignment plan over the last three months, particularly with Medical Sub-specialties, General Medicine and Paediatrics, has resulted in better overall provision of services to Blacktown and Mt DrUITT communities. This arrangement is sustainable and provides a stronger service and better patient care.

Recommendation: The reviewers support the realignment.

2. Clinical Leadership

There does not appear to be a Clinical Leader or Administrative Leader to champion Mt DrUITT Hospital.

Recommendation : that Mt DrUITT Hospital should appoint a clinical executive team. This should include the Director of Medical Services, a Physician, a Surgeon, A Nurse and a Community Representative.

3. Centre of Excellence

An opportunity exists to develop Centres of Excellence at Mt DrUITT Hospital.

Recommendation: that Centres of Excellence at Mt DrUITT should involve: Elective Surgery, Paediatrics, Palliative Care, Aged Care/Rehabilitation and Aboriginal Outreach services.

4. Emergency Department

A determination needs to be made, in view of ongoing workforce issues, about what clinical services the ED can and cannot offer. The community perceives that the Mt DrUITT Emergency Department offers 24 hour a day, 7 day a week comprehensive services with appropriate staff. This perception needs to be addressed.

Recommendation: that the Emergency Department should be closed, re-badged as an Acute Care Centre, or other models of care be explored. If adequate staffing could be secured, such a centre could operate 24 hours a day, otherwise it should operate only between 0700 and 2300.

5. Community Liaison

Mt DrUITT Hospital has a close relationship to the local community and this community does have special needs. The community genuinely

wants to be involved in discussing future plans for Mt Druitt Hospital. They have also been involved in considerable fund raising.

Recommendation:

- a. that Mt Druitt Hospital clinicians should communicate with the community about the changes.
- b. that a member of the community should be appointed to the Mt Druitt clinical executive team.

6. Review

As the population demographics are changing and population is increasing rapidly this should be regarded as an interim arrangement for the next three years.

Recommendation : that this proposal should be evaluated after 12 months.

Appendix 1

Contact List for Blacktown/ Mt Druitt Hospitals report

The following people were spoken with:

| | |
|-------------------|------------------|
| Aboriginal Elders | Tony Barrett |
| Tony Burrell | David Chipps |
| Gary Cheuk | Chris Clarke |
| Ros Crampton | Michael Datyner |
| John Dent | David Dunn |
| Michael Fearnside | Michael Flynn |
| Julianne Gibbons | Mohan Gilhotra |
| Lyn Glanville | Richard Hanney |
| Michael Hession | Ralph Hilmer |
| Pramesh Kavoor | Andrew Keagan |
| Rick Kefford | Phil King |
| Peter Klineberg | Peter Lawrence |
| Margaret McArthur | Coral McLean |
| Nicole Morrissey | Kerrie Phelps |
| Dennis Raymond | Graham Reece |
| Julie Rich | Barry Robson |
| Peter Rophail | David Ruppin |
| Lorraine Shaw | Margaret Thurlow |
| Margaret Walker | Mac Wyllie |
| Peter Zelas | |