March 2022

Southern Adelaide Local Health Network-Report to the Board

A REVIEW OF UNPLANNED AND EMERGENCY HOSPITAL ADMISSIONS

DR MARK MONAGHAN

CONTENTS

INTRODUCTION

This review, a decade on from an initial review of ambulance ramping at Flinders Medical Centre (FMC) in 2012, was sought by the SALHN board to review concerns relating to performance with regards to emergency department overcrowding, long waits for ambulance transfer of care and long waits for patients requiring hospital admission.

The intent of the second review is to make comment and recommendations on the current performance and clinical practices at FMC including patient flow throughout the hospital, the impact of the Southern Health Expansion Plan (SHEP) on Emergency Department models of care and staff culture in ED. Progress against the initial 52 recommendations in the 2012 FMC report is also considered throughout this review to assist in informing priority actions and the need for targeted initiatives to be driven by a collaborative clinical leadership group to achieve transformative change.

The most recent review was conducted over 5 days commencing 14 March 2022 and involved interviewing staff from the FMC, Department of Health (DOH), South Australian Ambulance Services (SAAS), observation of ED processes at FMC, and a site visit to Noarlunga Hospital. From this work, I have identified areas that require review by the SALHN board and have made recommendations to address the identified challenges.

The caveat to all recommendations made in this report is that, as with the 2012 review, these observations have been made over a short period of time, are generally high level observations, and several are based on the weight of opinion from staff and will require further confirmation by data collection and analysis. This will be especially important in any reform embarked on in new models of care for the major admitters and in ED patient flow.

Again, as with the last review, all staff interviewed were generous with their time in providing frank feedback that always reflected their genuine pride and affection for their hospital. The feedback given by staff will naturally be biased to areas of concern or potential for improvement, hence the tone of this report will largely represent those issues.

The report is not intended to provide a comprehensive description of all services and quality initiatives at FMC. Instead, it will focus on areas of concern and opportunities to move forward in reference to the purpose of the review. The report consists of my major observations and a summary with key recommendations.

Once again, I am struck by the potential for FMC to be a high performing site, however, this will require committing to the difficult work of true clinical service reform of the unplanned patient journey, work that thus far has remained largely unaddressed or implemented.

I would like to thank everyone that gave me their time over the review week.

Dr Mark Monaghan

SCOPE

The review week included engaging with ED clinical staff, inpatient unit clinical staff, and bed managers through a process of 1:1 and group discussions and undertaking direct observations in ED and other clinical units to complete the following scope:

- An assessment of current practice and performance against the 2012 recommendations with advice on priorities for immediate refocus.
- An analysis of timeliness of ED admissions to inpatient units and advice on areas of focus beyond the ED to address issues of timeliness.
- A review of ED models of care/clinical practices that guide the flow of patients from triage to assessment/treatment through to admission or discharge with the identification of opportunities to improve these practices when compared with 'best practice'.
- With the expanded FMC ED and the subsequent inpatient reorganisation, provide advice on the optimum models of care to maximise the investment in the infrastructure to provide the best patient flow and patient outcomes.
- Provide guidance on the further development of a culture of continuous performance improvement within the ED.
- Consider other recent work including:
    - The SHEP review undertaken by EY (Dec 2021)
    - The subcommittee Improving Patient Workflow recently established to address whole of SALHN patient flow matters.

Major Observations and Findings

Southern Health Expansion Plan

The Southern Health Expansion Plan (SHEP) was completed in July of 2021. This $86 million investment incorporated capital works, movement of services, and $45.7 million in operating costs to support increased FTE over the following 4 years.

The service changes and capital works within the SHEP were interrelated, however the most significant, in relation to this review, were the 12 bed expansion of ED EECU into 3G, the consequent 14 bed reduction in AMU capacity, the overall expansion of ED including 12 ED cubicles, the dedicated paediatric area and changes to the time critical and resus areas of the ED.

While it is not for this review to repeat the findings, a report conducted in the 3 months post SHEP completion articulates outcomes against expected benefits. This report demonstrated that despite a reduction in average ED presentations of approximately 10% and a reduction in admissions of approximately 20%, there had been a deterioration in:

- ED length of stay (LOS) for both admitted and non admitted patients,
- the average number of patients waiting for a bed at 8am each day,
- the average time between admission request and ED departure,
- inpatient LOS.

It is worth commenting that the suggestion that a larger ED would eliminate ramping demonstrates a lack of appreciation of both the causative factors and the whole of hospital ownership of ramping. Ramping remains a consequence and a marker of access block to inpatient beds.

Progress against 2012 FMC Review Recommendations

In terms of assessment of current practice and performance against the 2012 recommendations, there appears to have been little observable progress across most areas.

There is evidence of good work through the Continuous Improvement program to analyse both bed flow and hospital capacity utilisation. Whole of hospital capacity data was suggestive of a temporal mismatch between capacity creation and bed demand being a major contributor to access block. More analysis is required to determine the true impact of both total and individual departmental bed stock on access block at FMC. It was noted however that the numbers of single rooms, especially in the COVID world, appear to be a challenge for patient flow, with the deficit estimated by the continuous improvement program team to be in the order of 16 rooms.

An important advance has been much improved visualisation of available bed stock at any given time, which is critical to effective bed flow. The recent introduction of the SALHN Operations Command Centre (SOCC) should be an opportunity to further this work. There also appears to be a pleasing collaborative relationship at the ED/SAAS interface, and the Head Ambulance Liaison Officer (HALO) role is a significant part of this. SAAS

representatives described a more coordinated approach to ambulance distribution, including load levelling than was evident on the previous review. However, lived experience by staff speaks to ongoing issues with multiple ambulances arriving in close proximity. I was not able during this review week to explore this in adequate depth to form a valid opinion on this.

Further promising work since the last review includes the hospital avoidance initiatives that have been developed in geriatric care and the SA virtual care service which is only recently formed. The latter has an impressive model and leadership and the potential to significantly impact on patient diversion from ED as it is doing in Fiona Stanley Hospital in Western Australia.

Probably the most disappointing lack of progress is in the redesign of the clinical services to optimise unplanned inpatient movement from ED to their destination inpatient teams. I believe this to be a more significant issue than it was a decade ago and continues to result in a high number of stranded inpatients and a combative referral culture that not only impacts staff wellbeing and patient care but also is a poor example for junior doctor role modelling.

Although I observed daily executive and bed flow engagement in critical ED overcrowding (code yellows), there is little evidence of engagement and shared ownership of this issue from the inpatient teams. The review in 2012 noted that the ED had ‘given up’ on trying to fight the battles required for inpatient referral and flow. It is my view that this is even more so in 2022.

The lack of contemporary models of unplanned inpatient ingress, especially in the major admission streams, with a difficult referral culture, unacceptable radiology (CT) turnaround times and a high ED inpatient load, continue to discourage ED efficiency, especially in areas such as early senior review, early admission decision, and referral.

The SHEP initiative as it pertained to the FMC ED was in my view poorly conceived and implemented. The pre-determined ED expansion into 3G, which had been associated with a deterioration in performance previously, is by many in ED and beyond ED considered a poor decision. As noted above, it appears that there was a view that an ED expansion would solve performance issues, including ramping. This was never going to happen in the absence of inpatient reform.

The process itself had a very quick turnaround time which many involved described as rushed. Six weeks were allowed for final designs and a further 6 weeks for internal fit out, a collective total of 12 weeks.

Due to the nature of the process, the models of care were developed to fit the expansion and not the other way round as should always be recommended. The senior ED staff articulated that they clearly expressed their view at the time that this would worsen performance and these concerns were ignored. There are differing perspectives as to the degree of clinical staff engagement in this process, but whatever the ‘facts’, this has resulted in a further disenfranchised group.

This quote comes directly from the 2012 FMC review: “It is the review team’s view that the strategy to apply models of care that were not locally generated based on sound clinical service redesign (CSR) principles, not locally owned nor based on specific local issues was a significant strategic error that to a large extent accounts for the lack of demonstrated

improvement". I would suggest that the application of the FMC ED aspect of SHEP is another example of this approach.

Emergency Department

FMC ED is not functioning at a level that I would consider excellent or efficient. There are multiple areas of concern, including:

- senior medical culture and practice
- nursing staffing attrition and levels of experience
- the relationship / lack of 'on the floor' collaboration between medical and nursing disciplines
- the department's projected attitude of dissatisfaction and isolation to the rest of the hospital.

The caveat to the above statement is that this is of no real surprise in the hospital environment in which they find themselves. I have observed an ED workforce chronically traumatised by the processes and dynamics that surround them, further exacerbated by the recent SHEP initiatives.

The ED expansion at FMC, in particular the EECU expansion, was based on modelling and external consultancy opinion that suggested that even with no access block the ED cubicle and current EECU capacity would be unable to manage the 90,000 annual presentations expected for the department. Given the limitations in expansion, and a difficult departmental layout, the only solution thought available was to expand into 3G by relocating AMU upstairs, and to expand the paediatric area.

I would make the observation that the ED modelling as I understand it was based on a LOS that was 'realistic' for the organisation with its current processes and challenges rather than an optimal LOS. In addition, EECU bed numbers are influenced enormously by processes such as radiology turnaround time, so the EECU requirement would be expected to reduce if these processes were attended to.

A negative pressure capable resuscitation room was considered necessary for COVID management, which took the place of several of the cubicles used previously for time critical patients and resus stepdown.

The changes to the time critical area are consistently described by ED staff as being a challenging to nurse, deleterious to patient safety, and negatively impacting on flow of the stepdown resus patients. The new negative pressure and paediatric resus room are not considered user friendly. How much of these are true challenges of the design of these rooms or a consequence of the attitudes towards the whole process are difficult to tease out, as on the face of it these appear to be adequate clinical spaces.

The EECU was expanded into 3G, and the whole 24 beds of that area are now under ED management. This space now accommodates true short stay ED patients and a cohort of stranded inpatients. This area is not physically distant from the main department but feels

very separate from the heart of the department. This has the effect of spreading ED staff thinly which generates ergonomic inefficiency.

The tone of the EECU is also quite different from the main ED, as it feels much more like an inpatient ward than an ED. This was raised repeatedly during interviews with ED nursing staff, who pride themselves on being ED nurses and not ward nurses. There is also an understandable tendency to staff the area with junior nurses which again impacts efficiency.

Flow to an EECU ideally is smooth. As soon as a patient is assessed as requiring greater than 4 hours of care but is unlikely to require inpatient admission, the clinicians should ideally identify them as an EECU candidate and they should move over to the EECU space. Instead at FMC ED, the area is often used to offload newly arrived patients as soon as the department becomes congested, again an understandable but inefficient process.

ED policy states that all patients moved to this area, particularly those waiting for an inpatient bed, are to have four hour plans put in place to ensure patient safety during the waiting period. Nurses estimate that this occurs less than 50% of the time.

The new paediatric area is a lovely clinical area, however the four short stay rooms currently are infrequently used at present. The general sense of clinical engagement in the paediatric area and their interaction with the greater hospital and admitters feels very healthy and in contrast to the mainly adult ED. There are some described challenges in the relationship between the dedicated paediatric group and the main department staff, and as with all dedicated paediatric areas with PEM staffing, it can be challenging for non-PEM staff to provide irregular or infrequent shift cover in the paediatric area. Again, FMC ED is not unique in this challenge and will need to navigate this as best as they can.

The ambulatory (west) area has the potential to be a very significant patient flow solution for the department but is currently functioning under capacity. It also appears to have a very lean nursing staffing model (generally 2 nurses) that will be impacting performance.

I noted the lack of a procedure room, which inevitably means patients requiring sedation supported procedures must wait for an available resus cubicle space. Another comment I would make is that new ED designs are now including a behavioural assessment area for managing possibly undifferentiated organic/toxicological/mental health patients who may present aroused and benefit from a cross discipline approach to their care. This might be another opportunity for the department moving forwards.

In terms of ED processes and staff performance, I would make the following observations.

A highly functioning ED has many hallmarks, including a cohesive medical and nursing team, a culture of early senior review of every patient, timely decision making and investigations, and early disposition decisions. Resus and trauma teams work reliably and effectively, the senior medical and nursing lead for each area works collaboratively to manage patient flow in their area and ensure Australasian Triage Scale compliance where possible.

Both my observations and reports from nursing and medical staff described an environment that is very different to this.

Other than resuscitation cases, staff described very little senior clinician review of their cases other than a discussion that occurred after the JMO had assessed the patient and usually commenced investigations. One junior doctor described being able to count on one hand the number of patients reviewed by a consultant at the bedside. The consequences of this lack of senior involvement should be self evident: delays in decision making, inappropriate or unnecessary investigations, clinical risk, potentially unreliable/inconsistent quality referrals to inpatient teams, and missed teaching opportunities.

Nursing staff describe very variable involvement by senior medical staff in patient flow within the department. Collaboration in this, including a coordinated medical and nursing approach to leading an area or team within the department was described as lacking.

There is a divided senior medical workforce, with many expressing their chronic disillusionment with a lack of reform in the inpatient space and their disappointment with the decisions made around the ED expansion. With this there is a clear lack of cohesion with and within the senior ED medical leadership, which must resolve itself for the department to progress.

I believe it is important to include that there is a significant proportion of the senior medical and nursing leadership who are critical of the decision making around SHEP. They lay the accountability for the perceived mistakes and deteriorating performance at the feet of the ED and hospital leadership. I would make the observation that in this case the leadership group had very little choice but to try and make the best of what they were mandated to work with.

In terms of medical staffing, there are an allocated FACEM FTE of 28, which I think is reasonable considering the podded nature of the department. The department will be running at 24.5 FTE when it loses 4 FACEMS to the new Mt Barker ED which will challenge internal capacity to manage leave unless corrected.

FACEM staff do 3 x 9 hour shifts per week clinically and one non clinical shift per week, with limited real governance of the latter despite comprehensively documented governance models being in place. The latter observation is relevant in that it is part of the picture of the culture of the department as it currently finds itself.

Middle grade and junior medical staff are rostered on morning, afternoon, and night shifts. There is no high activity overlap shift rostered, reportedly because this would not be a popular shift with the senior staff. Rostering to high activity is a well established practice in Emergency Medicine.

Registrars describe rarely seeing patients with their consultants. This is not a unique challenge for EDs however there is a training risk in registrars working in parallel and relative isolation from the department FACEMs.

From a nursing perspective, it seems the loss of a significant number of experienced level 2 and 3 ED nurses has had a palpable impact on nursing performance in the department. Approximately 30% of the ED nursing workforce would be considered junior, with recently increased numbers of TPPP (Transition to Professional Practice Program) positions in the department. Approach to offloading varies considerably at ambulance triage and clarity over who undertakes basic essential roles, such as stocking IV trolleys with reported debates

about who is responsible for this work, are reflective of the challenges ED nursing currently face.

There are also very different views on the adequacy of ED nursing staffing numbers, depending on whether one is speaking with senior ED nursing leadership or the directorate. The 1:3 plus 6 rostering according to the Enterprise Agreement (1:4 in EECU) is the agreed approach. As the views on this were so definite and divergent, I believe this requires further review. I would note that the FTE for Nursing education in the ED, which I believe was approximately 1.4 across FMC and Noarlunga, seemed comparatively low to me, especially with such a junior workforce.

In terms of ED performance, a significant barrier is the lack of KPIs for radiology performance. CT scan turnaround times, which average around 3.8 hours and anecdotally can be much longer during peak activity periods. This will be having an enormous impact on ED performance and are quite unacceptable. For an ED to function well, access to CT and reporting, even verbal, needs to be on demand for code stroke or severe trauma, and ideally within an hour for most other requests.

Another challenge articulated by virtually all ED staff I spoke with is the introduction of the new EMR system. It is expected that the first three months post introduction of such a change is generally negative, however the overwhelming message is that this system is requiring substantial workarounds to make it user friendly. A particular aspect that concerned me was the inability to ‘flag’ orders such as IV antibiotics for administration. In a highly functioning department with good communication this may be less of an issue, however in the current ED the risk is that patients will have delays in orders such as medications, which especially in an unwell patient could absolutely impact on care.

One observation worth making is the introduction of the External Priority Care Centres model, which has a current goal of 140 patients per week. This has had a mixed reception from ED staff. The cases that meet criteria are generally very quick turnaround and therefore do not have a major impact on access block. That being said, they are still patients that would require staff time to see and treat. Generally these patients are small numbers (approx. 10/day), and the resources to identify these patients include a senior ED nurse, and sometimes two, scouting the department for suitable patients.

I would suggest that in the current environment this seems a poor use of a precious resource. The other challenge mentioned was the potential redundancy of the advanced scope physiotherapist position in the department, as this initiative very much target’s their scope of practice. It will be interesting to see how this initiative matures, and there may need to be some consideration of the advanced scope physiotherapist role either contributing to this model or being predominantly based at Noarlunga ED.

Finally, I would like to comment on the management of ‘ramped’ patients. I believe the ED is aware and reactive to clinical risk, both in the waiting room and the ramped ambulance patients. ED staff see a disproportionate executive, health department and political focus on ramped patients over waiting room patients, despite the ramped patients having paramedics or ambulance officers in attendance. I do think the daily multiple calls and texts to the triage and ED shift coordinator is doing more harm than good and could be managed in a more constructive way. This was raised and discussed during my visit.

There is no doubt that any delay in access to ED, whether it be in waiting room or ambulance arrival, infers a degree of clinical risk.

No staff are unaware of the impact of keeping ambulances off the road. My observation was that all higher priority patients were offloaded if possible, however uncommonly this is not possible or just to the corridor inside triage and not an appropriate clinical space as none are available.

However there is a sense of resignation about ED overcrowding and ramping, which consequently normalises ramping and no doubt has an impact on the responsiveness of the department to this issue. This needs to change, however again this is inextricably linked to efficiency of ED processes, ED inpatient occupancy and the broader hospital discussion.

I am aware that the above description may be seen as critical of the ED. I reiterate the point that the performance of the department is entirely predictable in the current environment. The ED staff that I met were universally dedicated to their department and patient care. However, in an environment with a constant high inpatient load, an embattled referrals process, an absence of contemporary models for accepting patients into inpatient teams, radiology KPIs that aren't fit for purpose, and a disgruntled senior workforce due to an ED redesign that is perceived as having worsened efficiency, there is very few positive drivers for ED staff to maintain optimal processes.

Inpatients

My interviews with inpatient teams confirmed once again that the FMC staff have a strong focus on excellent care within their departments. There is an articulated understanding of the importance of efficient capacity utilisation, and some good work is being done by the surgical team to enhance capacity.

What was lacking in many discussions however was a fundamental understanding or ownership of the processes and challenges for inpatients getting into their service. There was a surprising lack of care about the impact that having a JMO as the referral point for the department would have on flow. A good example of this impact is a general surgical patient referred to a surgical JMO, who will only review the patient after a CT had been performed and reported in an environment where a CT can take many hours. This is poor care. If we add into this scenario a situation where the ED senior doctor has not seen the patient before referral, we have a referral pathway that is doomed to be problematic.

There is an oft quoted hospital ‘one referral policy’ that was raised multiple times during the week of conversations. This is largely ignored or unsuccessful. The reasons for this are articulated above. Fundamentally though this relies on a senior ED review of the referred patient to ensure the quality of referral. It takes only a few poor quality referrals before inpatient teams lose faith in such a process.

I came away multiple times with the strong impression from the inpatient leads of a dedication to providing the best care for the patient in front of them, but not to those that should or will soon be in front of them. This limited view is one of the fundamental causes of the performance challenges that the site is facing.

There were clear exceptions to this, with the Women's and Children's directorate standing out as an excellent example of ownership of the patient journey from the front door with a clear articulation of a stranded inpatient in ED being unacceptable care. Mental Health had a similar focus for their ED patients and Geriatrics with their admission avoidance work, although models such as CARE have a small impact on numbers at this stage.

In terms of the medical units, the AMU at FMC remains for me a problematic model. The unit clearly works very hard, it provides the easiest route into a medical bed, and with their reduced bed numbers due to SHEP, they have an extremely difficult time on-referring patients to subspecialties. Consultants are on site 7 days a week, though it was reported that the weekends consist of reviewing unwell and new patients, but generally not those that may be possible for discharge.

Contemporary high performing AMU models have a true 24/7 model, with consultant review several times per day with a shift model not unlike an ED. Other important aspects are dedicated timely radiology and pathology access, allied health, and clerical support for discharges 7/7. Frailty streams supported by acute geriatricians are increasingly incorporated into AMU models. My impression was that this does not describe the AMU model at FMC.

The general medical team have not created a home ward based model. Consequently there are multiple teams reviewing patients on any given ward, safari rounds and inherent difficulty in MDT communication and efficiencies. All this directly impacts on patient care. The argument that home wards can create inequity between teams as efficient teams get penalised is spurious in the setting of good departmental governance.

All the inpatient units referred to challenges in allied health, social work, and ward clerk presence on weekends as limiting factors in their capacity to effectively discharge 7 days a week. The weekend allied health staffing sits at 18% of the weekday staffing levels.

A final point worth making is the frequent feedback on the lack of High Dependency Unit (HDU) capacity in the hospital. There is a cohort of patients who ICU deem to be not sick enough for ICU care yet are too unwell for the wards. These patients will inevitably spend longer in the ED. It is commonplace for tertiary hospitals to have HDU capacity in some form, whether it is for non-invasive ventilation, those on inotropes with a ceiling of care, or those patients such as diabetic ketoacidosis who require more intensive monitoring. These areas may be ward based under specialty medical team governance or part of the ICU and its governance.

Patient Flow/ Bed Management

There have been significant efforts to enhance bed management at FMC, including the introduction of the SOCC, the integrated management system, and service redesign being done by the Continuous Improvement Program team.

Initiatives such as electronically identifying pending discharge and electronically identifying ready to admit from ED, where for both there is a demonstrated delay of hours from decision to execution, are promising if embedded well. As mentioned earlier, available bed visualisation has improved, and the initiative to have the patient support staff register when a bed is available is clever.

I noted that there are an extraordinary number of meetings each day that the bed managers attend to be updated on the current state, which I feel could be reduced with an electronic real time bed state solution. I am sure SOCC will be looking for ways to address this opportunity.

There seems to be a movement away from ward manager control of bed occupancy to a central model. Virtually all hospitals have this challenge of perverse drivers of behaviour at a ward level. A reported example of this would be the unwillingness at a ward manager level to free up single rooms to avoid outlier patients from another specialty.

A question for the organisation to consider is whether the perceived transition towards central control of patient movement as distinct from empowering, supporting, and holding accountable ward managers, especially now that the bed visualisation is in place, is the healthiest direction for FMC to take. It is well recognised that the disempowerment of managers can have negative consequences in terms of engagement and staff retention, and perhaps a stronger culture of ownership of the whole patient journey and performance accountability could be equally effective.

Staff Culture

The first point worth making is that no matter what the variant, case rate, or death rate, all health systems globally have been challenged by the COVID pandemic. Staff furloughing, reduced access to leave, new processes to adhere to and in the early stages, the real threat of carer illness or death has left all health workers relatively spent. It will be some time yet before staffing is stable and adequate and people have had a chance to rest and normalise. This will have undoubtedly had an impact on staff wellbeing and workplace culture in many sites and needs to be taken into consideration when assessing organisational performance and the pace of implementing change.

From an FMC perspective, my observations over the week were as follows:

Everyone I met was dedicated to their hospital and providing the best care they could to their community.

It was noted repeatedly in interviews, that staff did not feel there was a strong culture of accountability for performance across the hospital, particularly when discussing the performance of managers and senior clinical staff. It is difficult for me to comment strongly from such a short observation time, except to say that the lack of progress on recommendations from a decade ago suggests that this may well be an issue the current leadership needs to address.

As alluded to previously, there is a strong culture of 'turf protection and siloing' across the hospital. There is little sense of embracing the whole patient journey and access block as everyone's responsibility. This exists at both the medical and nursing level. This is concerningly evident in junior medical staff, which is a missed opportunity as it imprints a mindset that they will take into influential senior roles. There is in my view, very important work for the senior medical leadership to do in this space.

Leadership and Governance

I believe the lack of progression of many of the critical recommendations in the 2012 report is the result of a failure of leadership over the last decade. The areas that have been left unaddressed are the difficult ones that take the most time investment, engagement skill, and effort. In many ways, the progress that has been made in terms of bed management systems, positive though they are, are easy things to do. Much harder is to challenge the behaviours or attitudes of senior staff.

If the best efforts of executive position holders to change things have not been successful, another approach should be considered, such as empowered clinical leaders, clinical champions in different craft groups, collaborative clinical leader groups from across disciplines empowered to reform their shared patient journeys.

What I don't see at FMC currently is an identified enlightened clinical leader or leaders who can drive reform with their peers. I certainly came across people who I could see stepping into roles such as this, but I can't see that the organisation has embraced or invested in this concept.

There are challenges with the current divisional structures that need to be addressed. There is a challenging relationship between ED and the medical directorate leadership that I think needs to be discussed and possibly realigned. It is my sense that with the size of this directorate, there is a possible perceived difficulty in responsiveness to urgent issues.

While the actual directorate a given department sits under is in many ways academic, at the very least this change would signal a willingness to engage with the ED department which is greatly needed at this time.

Finally, I would like to make comment on the Chief Operating Officer (COO) position and lines of governance. The current solid lines of governance to the COO are few and make it difficult for that position to enact any effective change. If this position is seen as a predominantly corporate executive position, then this may be left as is. However I would make the comment that several clinical leaders commented that they would preferentially seek out the COO position if they needed things actioned.

I cannot however clearly see the influential leadership and change positions in the current structure. I don't believe they sit with the EDMS position currently, and the CEO position is unlikely to have the capacity to do this work. This leaves the co-director positions, which at this stage appear to be in a difficult position to enact the change that is required.

Noarlunga Hospital

Relationships with larger hospitals and their satellite smaller sites can be of great benefit to each site and the local community.

If the smaller site provides capacity for lower acuity, slower stream care, or elective surgical capacity, it can be a significant bed resource for the larger site that then focuses on higher acute care. This also allows the smaller site to provide niche excellent care without the pressure of being in a busy acute hospital environment.

Alternately the smaller site can provide an alternate ED service for the community, offering care closer to home, admitting acute patients that do not require tertiary care, and taking pressure off the acute patient load of the larger site.

Noarlunga appears to be a mix of both models. It has a beautifully designed ED with natural light, an excellent central flight deck, and vision of cubicles. It is staffed by experienced medical officers with FACEM support.

Effective use of Noarlunga capacity was one of the focuses of SHEP. The hospital itself is undertaking a good volume of elective joint surgery and has an aged care unit. Currently, the admitting medical unit has relocated to FMC, but I understand this will soon return to Noarlunga hospital.

The current challenge in the Noarlunga model is the lack of capacity behind the ED to hold onto acute patients on site. The medical unit when on site is limited by access to subspecialists and cannot take patients who require high dependency level care. In addition there is no acute surgical service. This necessitates an ongoing flow from Noarlunga ED to FMC, which due to the lack of available inpatient beds, resulted in excessive ED waits as SAAS were only willing to transport when a bed was available at FMC. The result of this was FMC ED agreeing to take these inbound patients into ED, further exacerbating the stranded inpatient numbers in the department.

So to me the question is a strategic one of whether there should be further investment in elective surgery at Noarlunga (such as urology, gynaecology, plastics) and/or whether the capacity of the site to hold onto more acute patients referred directly from the Noarlunga ED is expanded. I am sure this is something the current leadership continue to deliberate on.

CONCLUSION

Coming back to FMC a decade on was a privilege. Great staff and a hospital that people and the community take pride in were evident, but the lack of movement on some fundamental change has left a site that is underperforming and has left patients stranded in a struggling Emergency Department.

It seems to me that FMC needs a roadmap to navigate itself by, in which several key issues need addressing for the hospital to perform in the way the leadership group and clinical staff wish it to.

Critically these solutions need to be generated locally, however, I will suggest some ideas for consideration in the recommendations below.

Before listing the formal recommendations I would make the following comments.

Firstly, and most importantly, there needs to be a fundamental change in the ownership of the unplanned inpatient journey from the front door and models put in place to support this.

In my view, there needs to be a set of agreed, patient centric principles that define the development of further models of care.

An important one is that it should be considered unacceptable for patients destined for an inpatient bed to be stranded in the ED. This may be the safest place for them overnight in a small country hospital, but it is not in a tertiary site, and these patients fall between the cracks of team ownership, impacting access for the next patient. Inpatient care is not a core ED business nor a core ED skill. For the ED performance KPIs and hospital KPIs such as ramping to be expected to improve, this must change.

There needs to be a mindset shift in the destination specialty team that they have an obligation to get their patient under their care as efficiently as possible, as they can provide the best care for that patient. This very much includes the medical and surgical subspecialty teams, in particular the dynamic between general medicine/MAU and the medical subspecialty departments.

It is true that you can't teach or enforce culture or adherence to articulated principles, but strong enlightened leadership can embed them.

FMC needs to invest in performing as a 24/7 hospital. There needs to be an investment in out of hours (predominantly weekends) medical, allied health, and clerical support for the inpatient areas to enable better discharge practice.

The AMU model needs to be supported to change to maximise its potential, the surgical take model needs to move away from a JMO receiving referrals to an acute surgical unit type model and general medicine has in my view a clear opportunity for efficiency enhancement by going to ward based teams.

Ideally FMC should consider creating an acute assessment unit, provide 7 day a week senior decision making. 3G seems an appropriate space for this unit, however, this will be dependent on ED modelling (see recommendations below). Optimal LOS would be determined by bed numbers and data analysis on the percentage of 'short stay' cohort inpatients. As LOS and care are optimised when patients go directly to the subspecialty unit they require, hence there should still ideally be direct access to those units

The changes to the ED through SHEP need to be reviewed. As an initial step I would pull ED governance back to an agreed number of beds in 3 G (12 beds would seem a reasonable number), which would only be used for the ED short stay patient cohort. ED would have to refine its processes and how it utilises this bed stock, as currently these are not efficient.

Stranded inpatient would occupy the other 12 beds, but this area should be removed from ED and managed by inpatient medical, nursing and allied health staff.

Following this and aligned with inpatient reform as discussed above, I believe there could be the potential for the ED to extricate itself from 3G. This would require re-modelling with an optimal LOS calculation based on optimal ED LOS and optimal ambulatory stream performance., radiology turnaround and minimal inpatient occupancy of ED.

The situation of ED sitting under the medical directorate needs to be reviewed. As mentioned above I don't think it should really matter what directorate a department sits under as long as the leadership of that directorate has effective relationships with its departments. It may be worth considering, as an interim while changes are underway, sitting the ED under the COO position.

KPIs need to be developed to match new models of care and then applied appropriately. Ramping for example is a whole of hospital KPI, as is inpatient ED occupancy, and needs to be clearly communicated as such. Time to senior review in ED will be an important measure as part of reform.

Finally, ED needs to attend to their performance, and I address this, especially to the senior medical staff. My belief is this will be as beneficial for them personally and professionally as it will be for the patients of FMC. However, as I will reiterate, this change can only be successful when the above changes have been truly and fundamentally addressed.

RECOMMENDATIONS

1. That a small number of senior clinical leads are identified and allocated FTE, from the Medical, Surgical, and Emergency departments to develop, within an agreed timeframe, contemporary models of care for unplanned patient ingress into the hospital. These clinical leads would ideally not currently hold director or co-director positions, and in my view would have the COO as their executive sponsor.

2. That the hospital leadership works with the senior clinician leads to creating an agreed set of principles as discussed above to guide these models of care.

3. That there be consideration of an interim solution of decoupling the ED from the Medical Directorate and having it report directly to the COO position.

4. That the hospital invests in weekend staffing (medical, allied health, clerical) to support maximal weekend discharge practice.

5. As an initial step, that EECU be contracted back to 12 beds in EECU and strictly only utilised for ED short stay patients. Inpatients awaiting beds would be managed in the remainder of 3G under inpatient medical and nursing care.

6. That Medicine and Surgery create contemporary models of inpatient ingress, including a potentially co-located, acute medical unit (AMU) and Acute Surgical Unit (ASU).

7. That the major admitters work with ED to create agreed on processes that allow for undifferentiated patients awaiting investigations to progress through to the unit. This relies on ED committing to a "no exceptions" policy of every patient being seen and assessed by a senior decision maker, and a documented 4 hour plan for every patient.

8. That these acute units accept direct admits or transfers from Noarlunga that have been assessed by a senior ED clinician.

9. That the ED remodel its capacity needs and determine if it is possible to reincorporate EECU back into the north section of the main ED and extricate itself from 3G.

10. That, in parallel with the inpatient initiatives, ED commit to addressing their performance issues and identify ways to enhance flow through their department, with the senior medical workforce having a lead role in this work.

11. That Input needs to be provided into resolving issues regarding ED culture, cohesion and leadership.
12. That the ED nursing staff contributing to the External Priority Care Centres Program be reabsorbed back into the ED workforce.
13. That ED nursing allocation to the ambulatory (west) area be increased by one per day and evening shift.
14. That there be consideration of incorporating a procedure room and possibly a behavioural assessment cubicle into the ED design.
15. That a ‘flag’ be incorporated into the EMR such that urgent patient treatment orders such as IV antibiotics are highlighted for nursing staff.

16. That the hospital urgently negotiates performance KPIs with their radiology provider to bring response times in line with contemporary practice.
17. That, on return of the medical unit to Noarlunga, consideration be given to optimising patient retention on site. This may need to include telehealth links to FMC for specialty clinical input where required.

18. That FMC creates a high dependency area with 4-8 beds, with the number of beds confirmed by data analysis. This could be considered within the acute unit area and under their governance.

19. That KPIs be developed alongside these new processes and applied to each area appropriately.