Govt Administration Committee "A"
Sub Committee Enquiry into the Cost Reduction Strategies of the Department of Health and Human Services

Submission: 25th November 2011

Impact Statement On Current And Future Cuts To The DHHS Budget & Services

These points relate mainly to Royal Hobart Hospital **Critical Care** resources/services, however, there is also reference to the impact outside of the Department of Critical Care Medicine because the health issues of all areas influence and interact with each other.

Introduction:
The Intensive Care Unit (ICU) of the Royal Hobart Hospital's Department of Critical Care Medicine (RHH DCCM) treats between 1100 and 1200 patients annually. It is the only tertiary level ICU in Tasmania – a state which has an inadequate number of ICU beds - and treats all critically ill patients except patients needing organ transplantation. The ICU submits data to a national quality assurance database and has performed well when benchmarked against other tertiary level intensive care units, and has saved the lives of countless Tasmanians who otherwise would have died. The ICU also provides care to patients on the hospital wards through a liaison service, and a medical emergency response team.
The Intensive Care Unit has 15 physical beds, and has a budget to adequately staff 10 beds. In order to save Tasmanian lives the ICU has run to demand rather than budget, and activity has led to successive deficits, of which the nursing component alone would be several million dollars annually. The recognition by successive CEOs that the ICU performs a function for the "greater good" of Tasmanians has allowed these deficits to occur unabated. The RHH also does not have enough High Dependency Unit (HDU) beds available (i.e. beds of an intermediate acuity level, between those in ICU and those of the General Wards), and a number of patients who should be managed in high dependency either have surgery cancelled, or are managed in inappropriate areas of the hospital.
The current health budget has cut services, and a requirement for the ICU to run to the historic budget (or a reduced budget) would lead to the closure of at least 5 of the ICU beds, and a reduction in patients treated of several hundred per year. Options for these patients would be transfer interstate, cancelation of surgery (and an increase in deaths on theatre waiting lists), treatment on lower acuity wards or palliation. The net effect would be the unsatisfactory transfer of critically ill patients and their families interstate, or an increase in avoidable deaths.
A reduction in medical staffing of the ICU has been mandated from 2012 onwards, and the impact of fewer, more junior doctors will have an adverse effect on the delivery of safe patient care for critically ill patients in ICU as well as those patients who are genuinely unwell on the low acuity wards.
ICU function is dependent on having adequate nurses at the bedside. An ICU patient is cared for by a nurse at the bedside 24 hours a day. The current strategies for dealing with the hospital budget has stopped the training of these specialized nurses, and has put great pressure on those remaining to work extra hours to care for the critically ill patients. Over time these nurses will become disillusioned with these demands, and those who are able will look for work interstate where conditions are much better. If we lose these skilled nurses from the state, the ICU would not be able to function, even if fully funded, and a vicious cycle will occur of nurses continuing to be over worked and being lost from the state. This will have repercussions for many years even if there is an easing of budgetary pressure.

- **A.** Impact seen **immediately** with reductions/cuts –
    1. **Refusal of admissions to ICU**: Unspoken but real pressure on Emergency Departments (ED) and Intensive Care Units (ICU) to deflect/refuse admissions that otherwise might be offered full medical intervention (at the level offered prior to the cuts). There is a real message out there that the community needs to consider/accept a lower level of care, however, hospital or DHHS administration will not specify how this should be implemented at the acute care 'coal face', and at present the community has not been informed that there will be an increase in preventable deaths. The onus will be on clinicians faced with the major shrinkage of resources available to them.
    2. **Greater reduction in ward and ICU beds for elective surgery**: With fewer surgical and medical ward beds all elective surgery will be affected **to a greater extent** than the planned 'controlled' reduction in elective procedures. This is due to the fact that with fewer beds acute admissions will flood the hospital (taking beds in preference to elective patients).
    3. **Wastage of limited ICU bed resource**: Increase in ICU bed block due to fewer general ward beds into which to discharge patients from ICU. ICU beds will then be 'wasted' on patients not requiring the higher level of care and hence the available critical care resource is diminished, and patients needing ICU immediately will have to be cared for in inappropriate areas where they will continue to deteriorate.
    4. **Inappropriate use of limited ICU bed resource**: Recovery ward overload (due to increased day case 'recovery patients') has already impacted on ICU beds, where patients are sent to ICU to recover from an anaesthetic.
    5. **Elective surgical cancellation escalates**: Points 2, 3, and 4 above will increase the number of elective surgical cancellations for a third consecutive year - (56 cancellations in 2009, 73 in 2010).
    6. **Increased risk of unplanned 'surge activity'**: It is possible that in order to have patients operated on (i.e. in the interest of their patients) surgical units will not book HDU patients (to avoid being told they can not start when beds are unavailable). Then post operatively will refer the cases as emergency referrals or manage them on their own wards in an inappropriate environment for the level of acuity/monitoring requirement.
    7. **Increased transfer of patients**: Inter-hospital (to private) and interstate transfer of patients we are unable to accommodate in the shrinking RHH. Impact on DHHS budget, Melbourne hospital work load, families travelling when interstate.
    8. **State-wide impact**: The RHH is the state referral centre for Neurosurgery, cardiothoracic surgery, vascular surgery, burns and major trauma. The reduction in ICU bed availability here will impact on the ability of NWRH and LGH to transfer patients for specialist care resulting in transfer to mainland centres. There is no guarantee that these patients will be treated in Victoria, and so there will be issues with "finding an available bed", transportation of critically ill patients, and having adequate access for families, particularly in the situation where their loved one dies. It is possible that a payment may need to be made at a jurisdictional level to cover costs, and likely this would be in excess of the cost of treating the patient in the state.
    9. **Inadequate medical staffing of ICU**: Decrease in the Registrar (advanced specialty trainee) establishment leads to more time the ICU loses Registrar cover on the floor at night when Registrars are assessing and reviewing patients on wards and in ED. This leaves the junior (Resident Medical Officer, RMO) in ICU and an increased risk to safety of patients should emergencies or deterioration involve ICU patients. There is also reluctance to extubate (remove from the ventilator – a potentially high risk event) patients, resulting in delays in ICU discharge. The frequency and period of time the ICU Registrar is out of the unit is increased further with the new '4hr rule' in ED.

in ED. ICU registrars are referred to by ED staff more often and earlier (in the work up/investigative phase) and thus leave the ICU understaffed. Morbidity and Mortality review has captured examples where clinical problems have been overlooked as a result.

10. **Critically ill patients remain on general wards**: Delay in the admission of deteriorating ward patients to ICU due to ICU being full/bed blocked. This already occurs as identified in recent Mortality and Morbidity meetings.
11. **ED patient discharge block**: Delay in the admission of patients referred from the ED which will impact on the ability to move patients from ED within 4 hrs – and result in subsequent penalty imposed by the Commonwealth Government.

- B. Impact **within 6 months**:
    1. **Delayed management of seriously ill ward patients**: As a result of the reduction in medical staff in ICU increased reporting is likely of delayed management and adverse effects in patients for whom the Medical Emergency Team (MET) has been called. . The inability of the ICU registrar to immediately attend MET calls 'after hours' occurs when the relative risk to ICU patients is judged to be greater than that of patients external to the department. With the reduction in after hours medical staffing such situations will exist at least on a weekly basis at which time MET calls will be given second priority to ICU patient care by the registrar and so they can not attend (until the consultant is called back from home). The Deteriorating Patient Project is a nationally driven Safety and Quality project aimed to prevent patient deterioration prior to the point of a medical emergency. However, medical emergencies and requirement for specialised ICU teams (the safety net) will continue to occur but will be less supported with the cut in resources.
    2. **The Medical Assessment and Planning Unit (MAPU) becomes bed blocked** due to reduction in hospital beds with flow on effect on ED.
    3. **JMO training experience 'diluted'**: Junior Medical Officers (JMO) and medical students miss teaching/training opportunities especially those doing surgical and orthopaedic terms due to reduction in patient numbers. Acquisition of skills and sound medical practices are mainly developed and consolidated during these crucial first terms/years of JMO's practice. JMO concern regarding this deficit in their training experience has already been expressed by many staff and will influence their decision regarding future positions.
    4. **Impact on rostering of medical staff (inability to fill the roster):** Through the year JMO's leave the hospital and positions are often not filled because those wishing to commit to longer term (12months) positions and training programs already have a position. In the past we have relied on locums which will remain a 'thing of the past' now that use of locum positions is no longer facilitated. Consequently existing staff work extra hours. – **This is the case now** with an ICU registrar resignation resulting in other registrars (including senior regs and CMO – higher pay rate) having to cover shifts. The situation next year will be amplified given the DCCM establishment registrar numbers have been reduced by the CEO again.
    5. **Reduction in the 'pool' of available trained nursing staff** as a result of non-permanent staff leaving the state for their employment. With increasing demand on existing staff establishment there will be an increase in overtime shifts required of which leads to nurse burn out and increased sick leave. Note that the current DCCM workload is already in excess of the establishment FTE.
    6. **Inability to cope with surge in demand**: With reductions in staffing establishment and the 'pool' of staff referred to above the 'surge' capacity of critical care services will be significantly limited. Surge capacity is a crucial

feature to consider in any acute care service where demand fluctuation is the norm and episodes where activity exceeds unit capacity are frequent and represent high risk periods for patients.

7. **Cardiac Surgery**: Cardiac surgery has to compete with emergency intensive care load, and as these patients need intensive care post-operatively, this surgery is often cancelled. If the ICU has any reduction in beds it is unlikely that cardiac surgery will remain viable in Tasmania. It is likely that the recognition of this will take time, waiting lists will increase, and patients will die waiting for operations.

- C. Impact **within 1 year**
    1. **High quality junior medical trainees leave:** Good medical trainees are already considering their employment options and are more likely to move away through the year and select other hospitals during the mid year recruitment period in 2012
    2. **Reduction in education and recruitment of nursing staff**: Education of nursing staff within the unit will be decreased due to abolishment of the post graduate Critical Care Course (for the first time in 20 years). In other words the training and education of all staff (not just trainees) is influenced in the short term in addition to a major impact on future recruitment and skill mix with abolishment of the major training scheme.
    3. **Increased health burden of 'elective patients'**: Once 'elective patients' are now presenting in increasing numbers with acute deterioration, inability to function at home and needing community supports. If not acute deterioration in many cases there may well be increased difficulty/risk due to more advanced disease e.g. carotid endarterectomy, cholecystecomy. Such patients are more likely to require critical care support/monitoring.
    4. **Loss of effective ICU nursing recruitment tool:** Interest in critical care nursing by junior nurses diminishes due to abolishment of the Introduction to Critical Care Programme (running since 2004 this course has long been recognised as an important recruitment tool for our unit – 65% of participants continued on to Post Graduate studies and employment at the RHH. This will impact on future recruitment of staff.

- D. Impact **within 3 years**
    1. **Community health burden expands:** Bottle neck effect by the RHH on ability to deal with the community health burden. i.e. Back log of elective cases leading to an increased community burden of chronic health problems (e.g. osteoarthritis of joints and those needing replacement, gall stones, cardiac disease)
    2. **ICU inability to support specialist elective surgery:** Increasing proportion of non-elective admissions to ICU and consequently cancellation of elective surgery, especially cardiothoracic and neurosurgical surgery.
    3. **Inability to attract highly qualified/skilled medical staff:** Quality medical trainees and specialists leaving or not considering positions at the RHH due to limited clinical and training resources and diminished junior support staff.
    4. **Loss of accreditation** for training by learned colleges due to reductions in trainee experience, inadequate log book records, and loss of sufficient FTE of

qualified consultant (supervisor) staff. A reduction in critical care nurses obtaining critical care certificates will also impact on the DCCM obtaining accreditation.

Summary

Any change in funding to the ICU will lead to issues for patient care in the Royal Hobart Hospital as well as state wide. Unless the community accepts an increase in avoidable deaths, we will be faced with having to keep patients alive through the utilisation of the private sector, or interstate beds. It is likely that doing so will actually be associated with an increase in costs to the state. If nursing and medical expertise is lost to the state as a result of current policy, we may find ourselves in a situation where Tasmanians have a second rate health system for many years. It must also be mentioned that any death that occurs as a result of these policy decisions may lead to litigation, and this in itself will not only have a financial effect on the state, but will potentially destroy careers and lives forever.

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