AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

12 May 2015
Hon. Jack Snelling MP
Minister for Health
GPO Box 2264
Adelaide SA 5000

Dear Minister

APA proposal for configuring therapy facilities at The Queen Elizabeth Hospital (TQEH) to support the relocation of rehabilitation services from Hampstead Rehabilitation Centre (HRC)

Thank you for your letter of 15 March in which you responded to a joint submission dated 30 November 2016, from the APA (SA Branch), OTA (SA) and ESSA.

We note under Transforming Health $20 million has been allocated to establish rehabilitation facilities at TQEH, thereby enabling the transfer of rehabilitation services from HRC. These facilities include a new hydrotherapy pool, allied health therapy space and the refurbishment of three existing wards. We are pleased that Allied Health clinicians, through involvement in the User Groups, have been involved in the design of these facilities, and look forward to further consultation and engagement as the planning process proceeds.

Prior to receiving your response, and in response to our ongoing concern about the foreseeable plans for therapy space at TQEH, the APA was afforded by SA Health a site visitation to see 'first hand' the existing facilities at TQEH and envisage possible configurations of therapy and other allied health space in future. We came away from the site visit with a better understanding of what is being provided and what is potentially to come. On behalf of our APA members we would like to provide a further submission, presenting the main issues as we see them and providing some suggestions.

Background

SA Health's stated approach to rehabilitation includes:

- starting rehabilitation as soon as the person is ready
- integrating rehabilitation into metropolitan hospitals (instead of maintaining stand-alone rehabilitation facilities)
- providing outpatient care at clinics where inpatient treatments are provided
- developing statewide specialised interdisciplinary rehabilitation service teams that work across all care settings for the management of spinal cord injury, brain injury, burns and complex multi-trauma
- establishing regional specialised interdisciplinary rehabilitation services that work across care settings for the management of stroke, amputee, orthopaedic, neurological and geriatric rehabilitation
- expanding rehabilitation service capacity across the care continuum.

Transforming Health proposes that rehabilitation services currently provided in stand-alone facilities (HRC and Repatriation General Hospital) be integrated into metropolitan hospitals. Most of the rehabilitation beds currently at HRC will transfer to TQEH, the only exceptions being twelve acute rehabilitation neurotrauma beds at the new RAH.

South Australia
8/15 Fullarton Road, Kent Town, SA 5067 Australia
p: (+61 8) 8362 1355
f: (+61 8) 8362 2223
e: sa.branch@physiotherapy.asn.au
www.physiotherapy.asn.au
ABN 89 004 265 150

Issues

1. **Rehabilitation services need to contribute to the 'flow' of patients across the continuum of care**

Rehabilitation services need to be provided seamlessly, integrated across the continuum of care and complementing acute care services. Thus, rehabilitation services need to include the following aspects of care:

- early assessment during acute hospital stay (in-reach)
- acute rehabilitation where applicable
- prescription of equipment and provision of therapeutic activity as early as indicated
- transfers to inpatient and ambulatory rehabilitation services
- transition to community services
- outpatient services – including allied health.

It is noted that to date, consultation with clinical staff about the systems and facilities required for a seamless service to work effectively for increased patient flow has been very limited, although in recent months there has been some consultation with staff of the SA Spinal Cord Injury Service.
We look forward to the outcomes of these discussions being made available. It is our view that rehabilitation services need to be adequately resourced not only to target the specific needs of each patient, but to contribute to patient flow through the hospital system.

2. **The rehabilitation facilities built at TQEH need to facilitate a seamless service.**

We need to provide patient centred care in fit-for-purpose environment, supporting efficient use of resources. The proposals for therapy facilities at TQEH have not met the needs of any of the rehabilitation services. This means that rehabilitation stays are likely to lengthen, creating 'flow' backlogs in acute services. The limited facilities at the new Royal Adelaide Hospital for acute rehabilitation for brain injury and spinal injury mean that there is a heightened need for TQEH rehabilitation facilities to provide the full range of equipment, space and activities needed for best-practice rehabilitation.

We support the suggestion of custom-built wards and therapy areas for brain injury and spinal injury rehabilitation, to incorporate features such as home-like design in transitional living areas, and therapy spaces that promote higher frequency patient access.

3. **The implications of suboptimal adjacency of general rehabilitation wards and therapy areas at TQEH need to be addressed.**

We recognise that the major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price. We also recognise that fiscal sustainability is a concern for schemes that subsidise health care across Australia.

Intensive rehabilitation of inpatients at the TQEH, particularly for specialist services in spinal cord injury, burns and complex multi-trauma, will involve frequent transfers of patients from their wards to the proposed therapy areas for rehabilitation services. It has already been identified that patient groups who can't safely travel between areas, such as brain injury, need the ward and therapy spaces to be co-located.

The transfer of patients between the proposed ward and therapy areas raises two substantial challenges.

Firstly, the absence of lifts at the northern end of the Allied Health and Rehabilitation Building will result in comparatively long periods of time being spent in transferring patients from their ward areas to and from the rehabilitation facilities, if the current approach to spatial adjacency is adopted. The transfers are likely to involve patients located on the first floor being transported to the front of the ward by an orderly, to wait for an available lift down to the ground floor. The orderly will then need to push the patient approximately 150 metres along a corridor before crossing outside and across the courtyard into the Allied Health building. The most feasible alternative is a convoluted journey along the upper level of the AH&R Building, through multiple locked doors and a lift, and back along the lower level of the building. We believe that either option will tire and frustrate patients and their families, an outcome which is undesirable for intensive rehabilitation. It could also expose them to the "elements" of extreme heat and cold. Such an arrangement would also prevent patients making their own way to and from therapy, which many patients currently do at Hampstead, where the journey forms an important part of therapy, and encourages independence. Without this possibility, access to therapy would be decreased, which is a key factor that increases length of stay.

Patients attending therapy would have greater reliance on orderly staff, with a subsequent decrease in efficiency and higher cost. To be successful, this sort of patient transfer involves 'long-line' planning of the use of porters and ancillary staff such that patient care can occur in a consistent schedule that maximises the time of the multi-disciplinary professional team. The return journey for the orderly to deliver a patient for therapy will be at best 15 minutes. If we just consider general rehab numbers, which we understand are 43 beds, and patients attending twice per day, this will equate to 21.5 hours per day. This is a significant resource demand.

The second identified problem in the existing approach is that, despite goodwill from all parties, clinicians believe that other demands in the hospital context will cause the timing of ward-to-rehabilitation transfers to be unreliable. We believe that this will result in notable inefficiency in the use of rehabilitation and ancillary staff. It will also likely result in patients waiting for long periods to be picked up before and after therapy sessions, leading to negative patient experiences and further reduction in access to therapy.

4. Spatial use needs to be optimised

Senior clinicians who are preparing for the transfer of services from the Hampstead Rehabilitation Centre have been informally studying the efficiency of the use of treatment space at HRC and at TQEH, in order to determine ways to create optimise the use of the space without compromising patient or staff safety and amenity.

These clinicians have formed a view that, with consistent consultation and some coordinated scheduling, use of the existing rehabilitation spaces at TQEH could be made more efficient.
To be successful, this change in spatial use will require collaboration with the teams at TQEH and HRC, so that the team-based culture of the 'new' service is developed.

<u>APA Proposed approach</u>

Our proposed solution has four steps.

Firstly, we believe that the current models for the transfer under-estimate the likely demand for ambulatory based services. Transforming Health relies on significant expansion of ambulatory services and these services will need to be incorporated into the rehabilitation facility at TQEH. This means that the needs for outpatient therapy space and related staff office space need to be met.

Secondly, we believe that the following approach to the location of the services will be most likely to optimise the use of built infrastructure and staffing. Inpatient therapy needs to be provided in a multidisciplinary patient centred environment with patients able to access their therapists in the one location. Ideally the therapy area should be located in close proximity to the ward to reduce travel time, and provide the opportunity for patients to transport themselves to therapy.

Thirdly, we strongly recommend that there be a process of audit of the use of the existing treatment spaces. We believe that this will help to clarify needs and to highlight opportunities to increase the efficiency of use of the existing rooms.

Finally, although we believe that our approach will result in more effective use of TQEH resources, we remain concerned that staff space will be inadequate, and that the service planners need to re-allocate space close to the rehabilitation areas for staff use.

Our proposal is …

1. **Reconfiguration of the existing ground floor space in the Allied Health and Rehabilitation Building**

This would support the establishment of a multidisciplinary ambulatory therapy centre able to meet the needs of the patients of Central Adelaide Local Health Network. It would require appropriate resourcing of Allied Health professionals, supported by Allied Health assistants and administrative staff to deliver ambulatory based rehab 8am to 6pm, 6 days per week.

2. **Develop a separate therapy area for the delivery of general rehabilitation injuries.**

Ideally this would be achieved through building of an additional floor on the new building proposed for hydrotherapy and a spinal injury gym. This would allow patients to be efficiently transported a short distance from the general rehabilitation ward on level 1, and as patients achieve greater independence, transport themselves to the therapy space. This provides a patient centred approach, minimising the need for additional orderlies, and increasing therapy time for patients.

An alternative to the building of the additional therapy area would be consideration of a refit of the level 1 space in the Allied Health building. The current shared office space on this level could be converted to a multidisciplinary therapy area. A critical enabler for this option would be the provision of alternative office space can for Allied Health staff, including those currently accommodated in the building and those transferring from HRC. This office space would preferably be provided by building an additional level on the Allied Health and Rehabilitation Building, as per the original plans when this building was commissioned.

3. **Create custom-built wards and therapy areas for spinal injury rehabilitation, to meet the highly specialised needs of this state-wide services.**

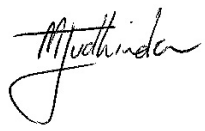
Facility needs, equipment and space requirements for the spinal injury rehabilitation service have been carefully documented by allied health staff working in this service at HRC, and submitted to the Central Adelaide Local Health Network. The APA supports the accommodation principles and needs outlined in this document and would like to be involved in reviewing the adequacy and configuration of the new space being made available for Spiny Injury at the TQEH. We understand planning is under review and some consultation with Allied Health Staff has occurred. It is been suggested that the planned area for spinal injury therapy space may now increase by approximately 50%, although we await confirmation of any such change. The APA would like to be in position to review the revised plans.

4. **Create custom built wards which incorporates custom designed therapy space for patients of the Brain Injury Rehabilitation Unit.**

Therapy space for brain injury patients needs to increase from the current proposal of using therapy space in the South Ground Ward at TQEH. The area is too small and therefore inadequate for this patient group who have specific cognitive and behavioural difficulties. It may be feasible to set aside some scheduled use of the therapy gym on the ground floor of the adjacent Allied Health and Rehabilitation building, if patient safety and transport efficiency issues can be addressed. However this arrangement would not allow the delivery of best-practice therapy for this patient group. Therapy delivered in the ward area is really what this patient group needs.

In closing, the APA believes the $20 million building and refurbishment budget to support the transfer of rehabilitation services from HRC to TQEH will not deliver fit-for-purpose facilities. Additional resources will be required to create facilities that are capable of supporting the provision of quality, comprehensive rehabilitation services. Key aspects are the creation of significantly more therapy and office space than has been planned. The APA stands ready to participate in the redesign of the plans to ensure future rehabilitation services at TQEH meet the needs of patients and contribute to the efficient flow of patients through the system. We look forward to further discussions with you to help realise this outcome.

Yours Sincerely



Martin van der Linden
President
APA (SA) Branch

CC: Premier Jay Wetherill
Chair of Ministers Clinical Advisory Group- Professor Dorothy Keefe
Chief Transforming Health Officer Marie Gerahty
Chief Allied Health and Scientific Advisor Catherine Turnbull
Hon. Stephen Wade MLC – Shadow Minister for Health