White paper response

The Mersey Community Hospital (the Mersey) will continue to provide a mixture of general hospital services to the local community as well as playing a vital role in a statewide hospital service network. (Exposure draft of white paper) - Page 7

Response

Currently we provide acute hospital services – public need to know that we are losing acute services. Patients will no longer be admitted at the Mersey for acute medical conditions such as:

- *Pneumonia – Chest infections*
- *Neurology conditions such as Bells Palsy TIA and Strokes*
- *CCF – cardiac failure*
- *Pain Management – back pain*
- *Pulmonary Embolism – PE*
- *Respiratory conditions – COPD, emphysema, asthma*
- *Metabolic conditions – DKA diabetic ketoacidosis*
- *Post recurrent seizure – post ictal*

*A presentation at the Devonport forum on Wednesday the 5th May 2015 stated 7% of 26500 presentations to the Mersey Emergency Department in 2013 – 2014 were admitted to the hospital for further treatment. This calculates to be **1855** patients a year that will need to be transported to another hospital for care. This averages out to be 5 patients a day.*

Where are these patients going to go with LGH and NWRH being bed blocked – no beds presently

The largest population growth in Tasmania in 2013-2014 was in Latrobe at 2% and the fastest growths were at Latrobe at 2% and Turners Beach/Forth and Port Sorell at 1.7% this was equal to Legana and Kings Meadows also at 1.7% (Australian Bureau of Statistics, Regional population growth 2013-2014) yet you insist in downgrading and reducing the services of the Mersey.

Medical staffing costs in the North West are very high. The North West region currently spends in excess of $10 million annually on locums to support the delivery of clinical services, many of which could be provided better and more sustainably by specialists currently employed in the Tasmanian system. (Exposure draft of white paper) Pg 7

Response

- *I would like to see the advertisements of permanent positions for specialist doctors at the Mersey Community Hospital. I believe that medical staff in Tasmania until recently have a much lower wage that the rest of Australia. Even with the recent increase it is still below average. If specialists were given a reasonable offer which would be above the award, they would be happy to stay and would be much less than Locum rates. I refer to Dr Luke McGuinns' response to the green paper that has been uploaded. Here we have a specialist that wants permanent employment but does not have it.*

A number of changes at the Mersey will result in a decrease in the complexity of some services provided. The current High Dependency Unit (HDU) will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre. These changes have been recommended by senior clinicians working in the region, due to concerns about safety and the quality of care that is able to be provided from the HDU as a result of a number of factors. These factors include low numbers of patients being managed in the HDU and ongoing recruitment difficulties resulting in high numbers of locum staff. (Exposure draft of white paper) – Page 7

Response

- *HDU – currently on first floor and has telemetry monitored beds for cardiac patients*
- *HDU beds are often at capacity*
- *SSU – within the ED department has 6 beds conditions for admission include patients that are stable but awaiting transport or need to be observed for a time.*
- *Senior clinicians working in the region that are recommending the SSU area to be used for critically ill patients requiring stabilising prior to transfer are clinicians from BURNIE*
- *The majority of patients needing transfer would need to go to LGH as it would not be cost effective to send them to a more remote facility like NWRH, to be flown back to either LGH or RHH*
- *NWRH and Mersey Community Hospital are both working at capacity, where are our patients going to go?*

With resources in the North West going into expensive services that are used by very few people, there are service gaps in clinical areas that impact on a large numbers of patients. Examples include pain medicine, rheumatology, neurology and rehabilitation services. As a result, some people are missing out on the services that they need access to closer to home. These are the sorts of services that people may require for an extended period of time.

The Mersey will have an enhanced role in providing subacute services such as palliative care, rehabilitation and geriatrics to the community of the North West. These are all important services that will be vital for the wellbeing of an ageing population with a high burden of chronic disease. (Exposure draft of white paper) Page 8

Response

- *Pain Medicine – will be a telehealth clinic in Burnie not Mersey -*
- *Rheumatology – will be a telehealth clinic in Burnie not Mersey*
- *Neurology – Burnie clinic – visiting clinician*
- *Rehab services palliative care and geriatrics – transport requirements and accommodation assistance for patients families travelling to see their loved one from North and NW of the state to Mersey. This will increase family of patients to be on the roads more, at very stressful times.*

There is also a set of services, including cancer services, where there has been ongoing difficulty in managing and delivering separate services in the North and North West of the state. When taken as a whole, the northern population can support these services. For this reason, the Northern Integrated Cancer

Service, operated from the LGH, will provide better integrated services across the North and North West of the State. Through the development of a critical mass of specialist workforce, the new linear accelerator will be opened and operated at the NWRH to provide vital radiation oncology treatment to cancer sufferers. (Exposure draft of white paper)

Response

- *No radiation specialist to operate the new linear accelerator?*

Public-private partnerships help us to deliver services where there are not enough resources to 'go it alone', and where duplication of services within both the private and public systems is not sustainable.
The ongoing pursuit of innovative change will support a constantly improving and adapting health system. Making better use of our health professional workforce, by introducing new models of care that use the full range of their skills and expertise, in particular in the nursing and midwifery workforce, has the potential to provide a more efficient overall health service. (Exposure draft of white paper) - Page 9

Response

- *Is this an indication that the Burnie Private Hospital will be used to contract maternity services?*

Submissions to the Green Paper process, including those from the Clinical Advisory Groups (CAGs), have identified a significant number of potential improvements to specialty services. (Exposure draft of white paper) Page 10

Response

- *Who is on the CAGs that works solely at the Mersey Community Hospital?*

The decision to release this Exposure Draft of the White Paper addresses a number of key issues identified in the first round of consultation:
• we need to be specific about the proposed changes and provide everyone with an opportunity to comment
• we need to continue to build on our consultation to date, including through more structured and targeted consultation with nurses, allied health professionals and doctors, and
• we need to understand the implications of the changes that are proposed, so we can identify the challenges that must be overcome to support access to services.
During the months of April to June 2015, the Department of Health and Human Services (DHHS) will lead a further round of consultation with key stakeholders on the proposed changes. This consultation will include:
• a second round of public and staff forums to provide information on the outcomes of consultation to date and to seek comments on the proposed changes
• a dedicated round of consultation with key stakeholders, with increased attention being given to the views of nurses and allied health professionals, and
• receiving any further written input. (Exposure draft of white paper) Page 11

Response

- *Who on the CAGs is soley from the Mersey? It would appear this is quite biased.*
- *There are no time lines in the white paper.*
- *The infrastructure is not there to support the changes*

24 hour Emergency Department (ED) services are currently provided at the NWRH and the Mersey. Advice from clinicians indicates that the complexity of cases currently taken to the Mersey via ambulance is too high for the ED and associated support services available on site. Into the future it may no longer be necessary to have the Mersey ED open overnight other than for those requiring stabilisation for life threatening conditions prior to transfer. (Exposure draft of white paper) Page 30

Response

- *Advice from which clinicians? Mersey clinicians?*
- *ED only open overnight for those requiring stabilisation for life threatening conditions prior to transfer – How can an ED be only open when there is an emergency? Still needs to be staffed? An ED needs to have staff capable of managing life threatening conditions. Most now are stabilised and transferred to LGH. This will never change and with the growing population in this area of elderly patients will actually increase.*
- *Emergencies are not planned!!!! Staff will not just magically appear?*
- *A very expensive service If only open for stabilisation as department will need to be staffed.*
- *Retention of nursing staff and allied health staff will be very poor as these staff will lose their skills.*
- *Patients that walk in have highly complex conditions*
- *Currently patients being transported to LGH and RHH can be ramped for long periods of time and are being cared for in their emergency departments for days whilst waiting for an acute bed in the hospital. How is this plan going to ensure patients have beds available in other hospitals and how are the families of these patients going to be able to support them when they are out of area?*

Scenario – patient at home in Devonport having a heart attack, all ambulances are out of area ramped at either NWRH or LGH. Patient dies.

Recruitment and retention of clinicians to the specialist-led model of care that currently operates at the Mersey ED has traditionally been difficult. There are high levels of locum use and this has a negative impact on the sustainability, quality and safety of the service that can be provided. (Exposure draft of white paper) Page 30

Response

- *Recruitment and retention of clincians and nursing staff will be impossible without services, it is hard to recruit nurses to Mersey now this will cause more recruitment issues retaining the experienced staff that we do have.*
- *Many of the locums have expressed interest in permanent positions at the Mersey but have been told that there are no positions available. These locum clinicians will not come out of the closet and tell the government this as they will lose their locum contracts.*

With future service reconfiguration it is planned that over night demand for ED services will reduce to the point where a 16 hr ED service will be sufficient other than for those requiring stabilisation for life threatening conditions prior to transfer. (Exposure draft of white paper) Page 31

Response

- *Staff do not magically appear when there is an emergency*

These changes to the ED at the Mersey will ensure that the local community will continue to be able to access urgent care when required (Exposure draft of white paper) Page 31

Response

- *As long as it is in the 16 hours the ED is open*

The current HDU at the Mersey will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre. (Exposure draft of white paper) Page 31

Response

- *Please explain what the current SSU is?*
- *How many beds will this be and where?*
- *Who will staff it? Clinicians? FACEMS?*
- *Transfer takes hours this will be worse with all the patients from this area going to be transported by ambulance to NWRH or LGH as we will not have any acute beds.*

As recommended by the key critical care clinicians and the ED CAG , these changes need to be supported by appropriate acute and non-urgent transport arrangements. These include:

A clear Tasmanian ambulance destination policy that is well communicated to and understood by the public. This describes which hospital the patient will be transported to in certain circumstances.

– This policy should reflect the role delineation of the hospitals. Patients should not be transported to any hospital that does not have the capacity to manage them and their condition. This will reduce subsequent inter-hospital transfers and the associated decrease in safety. (Exposure draft of white paper) Page 31

Response

- *Who are the ED CAG? Who solely speaks for the Mersey?*
- *Ambulance Tas are now required to ring through to the NWRH ED on all alpha and bravo patients so that their ED can decide where the patient is to go. Why has this happened and why does the Burnie ED have this decision? Where was the consultation to this change? Why do we have patients transported Burnie via ambulance then transported to Wynyard airport to be airlifted to LGH?*
- *Mersey has the capacity to manage critically ill patients for transfer to LGH why then do they go to Burnie?*

A transport system for the patient and their family so that after their acute care is provided at a non-local hospital they are able to return to their local area in a timely fashion and at a reasonable cost. (Exposure draft of white paper) – page 32

Response

- *This is contradictory as in this white paper its saying that after the acute episode patients are then to be sent to Mersey for their subacute care from North and Northwest. – Mersey is not every bodies local area.*
- *How many patients do you envisage will be coming to Mersey from Burnie and beyond (NW) and Launceston (North)*
- *Where are the families going to stay?*
- *Who is going to pay for the accommodation and the transportation?*
- *What is the timeline?*

An enhanced bus/other transport service so that the families can visit their in-hospital relative easily. This is extremely important in the North West as travelling out of area is a

Significant financial burden. (Exposure draft of white paper)

Response

- *What about the families that are travelling to the Mersey often for long periods of time as palliative, geriatric and Rehab can sometimes take long periods of time, or are these going to be local patients?*

The proposed clinical service profile substantially increases subacute service delivery in the North West and in the North by utilising the Mersey to deliver better subacute care. This will provide a greater level of access to nurse-led subacute services in the Mersey's local community, supported by specialist medical practitioners in the North and South, which can also be accessed by patients and consumers in the South, North and broader North West. It is proposed that there will be overnight subacute services and care delivered by nurse-led multidisciplinary teams. (Exposure draft of white paper) Page 34

Response

- *What does this mean? In the North West and in the North? Will patients from the North be sent to the Mersey for Rehab? What about all the transport issues for family in this scenario? What is going to happen to the rehab department at the NWRH?*

Maternity services in the North West are currently provided at the Mersey and at the NWRH via a private provider. Approximately three quarters of these births occur at the North West Private Hospital.
There have been numerous reviews of maternity services in the North West. All of these reviews have identified a need to change the way that the services are delivered. These recommendations are based on:
• poor safety of the existing service model
• ongoing recruitment difficulties that have necessitated long-term use of locum obstetric staff at the Mersey, and
• suboptimal clinical outcomes.
The delivery of maternity services in the North West continues to be fragmented and there are significant safety challenges in delivering the service. This includes ongoing difficulty in recruiting consultant obstetric staff and oncall paediatric support being provided from Burnie after hours. (Exposure draft of white paper) Page 35

Extract from Dr Luke McGuinn Green paper response –

The unusual arrangement in the NW whereby a private health company, HealtheCare, based at the North West Private Hospital in Burnie, has an open-ended contract with the DHHS, to provide all the Maternity services in the Burnie area, both public and private.

It is perplexing why, when all the other after-hours surgical services were withdrawn from the MCH recently, the Obstetrics & Gynaecology service continues. This is a 24-hour surgical service with the necessary 24-hour specialist cover and operating theatre access. If it was not for this, I am told that the MCH would already be a day-surgery Hospital, as some say, it is proposed to become. I have heard various rumours as to why this is the case, that the 24-hour O&G service continues at MCH, but two of them are fairly constant and they are that the Burnie end of the service does not have the capacity to take on the 400 deliveries/year currently done at the MCH and that all of the maternity service provision at the Burnie end of the service is by a private company in a private Hospital under a highly unusual, open-ended contract with the DHHS. It is often stated around NW Tasmania that because of this unusual contract with the private healthcare group, it costs the DHHS $10,000 per delivery in Burnie whereas the National average is about $4000. If this is true,

simple back-of-the-envelope calculations, with a lot of other (probably incorrect) assumptions, suggests that to move the 400 MCH deliveries to Burnie would cost an extra 2.4 million dollars a year (an extra 4 million at Burnie – 1.6 million currently at MCH). However, I understand that the Federal government is still funding the MCH until the middle of this year so that it may not currently be costing the DHHS 1.6 million a year to deliver 400 babies at the MCH. Currently, the NW area does about 1400 deliveries a year with approximately 1000 at the Burnie end and 400 at the Devonport end. So whether it is a capacity issue at Burnie or the cost of moving 400, currently public deliveries, into the private sector, or a combination of these two factors, I do not know but the fact remains that the MCH still maintains a 24-hour Obstetric & Gynaecology service even though other 24-hour surgical and speciality services were withdrawn some time ago.

High dependency unit (HDU)

The Mersey currently provides HDU services.
The current HDU at the Mersey will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre.
An average of only six patients a year over the past six years have required urgent ventilation.
With these volumes, critically ill and injured patients are more safely and efficiently managed at a higher level facility.
A short stay unit will be better equipped to stabilise and prepare patients for transfer – Page 46
(Exposure draft of white paper)

This is incredibly misleading to the public, giving the impression the HDU only see 6 patients a year. This has come up in conversation many times and it is ludicrous to think a department would be open for 6 patients a year. HDU is often at capacity and is a critical service to a functioning hospital providing safe services to the public.

Emergency Medicine

The Mersey currently provides a level 3 emergency medicine service.
This will remain a level 3 service.
The model of care and staffing skills mix at the ED will be enhanced to better meet the needs of presenting patients and improve the quality and safety of care.
Patients with serious conditions picked up by ambulance will be transported directly to the NWRH or the LGH with the exception of patients with acute chest pain who will be stabilised prior to transfer.
Increased workforce support will occur through the introduction of 'rural generalists' (physicians with both general practice and emergency skills) into the ED.
(Exposure draft of white paper)

The ED department must be overseen by an experienced emergency physician and not a generalist GP. There are little support services already at the Mersey and it is essential we keep what we have.

If it was a workable model employing GP's then why has this not already been done instead of hiring locums?

Infrastructure not in place

Patient transport not in place

Cancer Services page 47 - *When will this be staffed at NWRH?*

Acute stroke services
The Mersey currently provides a level 4 service. This will be changed to a level 3 service.
Both the NWRH and the Mersey treat small volumes of patients with stroke. By consolidating services at the NWRH and by establishing increased subacute service capability (rehabilitation services) at the Mersey, service quality can be improved overall Page 47. (Exposure draft of white paper)

Increasing transport times will delay early assessment and treatment as well as imaging. Delays in these factors have been linked with poorer outcomes in stroke patients.

Mersey catchment area has the oldest growing population and services that are time critical should be provided in the area most in need.

Are we able to get a report on stroke patients in our area, not those that present to hospitals as many are transported to NWRH that are from Mersey catchment area?

Patient and family Transport issues.

Patient has a stroke in Latrobe, they are transferred by ambulance to NWRH when stable they are transferred back to Mersey if unstable could potentially be transferred to LGH or RHH?

Why would you transfer patients away from the facility with the higher level of specialist service?

I fail to see the benefit of taking this service off Mersey.

Rheumatology and pain management– pg 44
This service would be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology and pain management services.
The service will be supported through telehealth. -– pg 44
(Exposure draft of white paper)

Will this be at the Mersey?

Will it be a Telehealth Clinic?

Gynaecology services
The NWRH currently provides a level 4 gynaecology service which includes the provision of a diagnostic service and surgery by specialist gynaecologists
This service remains level 4. Inpatient services for the North West will be consolidated at the NWRH. Pg 44
(Exposure draft of white paper)

Losing this service altogether?

Maternity services

The Mersey currently provides maternity services at level 4.
Maternity services inthe North West will be re-configured to improve their safety.
There will be one level 4 maternity service provided in the North West.
The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the most appropriate location for service.
The NW currently has a higher rate of pregnancy complications than the other regions.
Consolidating services to a single site will improve the safety, quality and sustainability of maternity services in the North West.pg 49
(Exposure draft of white paper)

See Dr Luke McGuinns response to green paper

Where in Burnie will this be placed?

Drug and alcohol services

No level at present. Increase to level 4.
Establishment of mental health services enables on-site, collocated drug and alcohol services to be provided to residents of the North and North West of Tasmania. Pg 49
(Exposure draft of white paper)

What is this service?

Inpatient?

Business hours?

Outpatient Clinic?

Geriatrics

There is no geriatric service provided at the Mersey.
Level 4 Geriatric services across the North and North West.
The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.
The North and North West has significantly fewer specialist geriatric resources than the South.
These services could be provided locally, reducing the need for patients, their families and carers to travel. Pg49
(Exposure draft of white paper)

Across North and North West, what does this mean?

This could provide? What does this mean?

Will work with clinicians and Australian Government. When will a decision be made?

Palliative care Services

There is no palliative care service provided at the Mersey.
We will investigate the feasibility of a level 3 palliative care service.
The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.
There no palliative care beds in the North West. Pg 49 (Exposure draft of white paper)

Investigate the feasibility?

No Decision?

Rehabilitation services

There is no rehabilitation service provided at the Mersey.
We will investigate the feasibility of a level 4 rehabilitation service across the North and North West.
The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.
The North and North West have fewer dedicated rehabilitation beds than the South for the same population size.
These services could be provided locally, reducing the need for patients, their families and carers to travel. Pg49 (Exposure draft of white paper)

Investigate the feasibility

North and North West, was does this mean?

No Decision?

In Summary

All acute services stripped from Mersey, HDU and Gynae gone, feasibility studies for Rehab, Geriatrics, and Palliative care services. No decision on Maternity service.
We may be able to travel to Burnie for Pain, Neurology Urology and rheumatology clinics.

You continue to say no hospital will be downgraded, however this summary suggests differently.

Your presentation at the forum amused me when you started that there would be 7500 fewer people travelling from the North West to Launceston per year with additional services in the North West, yet you also announced that you were increasing funding to Patient transport by 14 million dollars over four years. This is quite contradictory.