Tasmanian Health Organisation – North West

Tasmanian Government

THO-North West response to Delivering Safe and Sustainable Clinical Service – exposure draft White Paper

The exposure draft White Paper outlines how Government will reform the design of the Tasmanian health system to deliver better health services and achieve its vision to have the healthiest population in Australia by 2025.

In principle, we support the majority of service profile and role delineation statements outlined in the exposure draft. We would recommend changes to the language used within the paper to reduce "siloing" of services through being more inclusive of the team practice requirements to achieve health outcomes. For example instead of using "nursing lead" models, these could be better described as "team lead models" thus reflecting that any member of the team whether they are allied health, nursing or medicine can provide leadership based on merit and not on the basis of their profession.

It is noted that some of the patient examples within the exposure draft White Paper were factually incorrect. Specific reference is made to rehabilitation and we advise currently patients in the north-west are not sent to a nursing home post hip replacement. Rather, we provide rehabilitation and other home care packages such as the Commonwealth Transition Care program.

The strengths and difficulties of the role delineation model proposed are well evidenced as its focus is on inputs, rather than desired health outcomes. However, while it is useful for co-ordinating services within an area and it also provides benchmarks to compare services offered between different areas; the model is unable to evaluate the competency levels of staff, other than obliquely through assessing the frequency with which they perform certain procedures. It would also be inappropriate to be used as a purchasing tool as purchasing is ideally output focused.

We are aware that Government has begun the process of developing key strategic documents to support the delineation framework being capital and workforce strategic plans. We would ask that the capital plan also consider additional outpatient clinical room capacity to support the proposed increases of service in the region to ensure the proposed service changes occur in a safe, effective and efficient way.

We would also recommend that Government consider the development of a Strategic Asset Management Plan, as reconfiguration of health services will mean the reconfiguration and likely purchase of costly equipment for hospitals and operating theatres.

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20 May 2015

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Clinical Support Services

Anaesthetic Services

Any scope of practice changes for obstetrics and emergency surgery at Mersey Community Hospital (MCH) and North West Regional Hospital (NWRH) will have a direct impact on anaesthetic service in the north-west.

The current arrangement regarding anaesthetic on-call is expensive, as there must be three anaesthetists (first on-call Burnie, backup on-call Burnie, on-call Mersey) on-call every night. Unless and until emergency surgery and obstetrics are confined to a single site, this is not going to change.

With regard to the establishment of an exclusive day surgery centre at MCH, this only has merit if birthing is not at the same site as the day surgery unit. The proposed rationale for this change is to decrease the number of elective day surgery cases that are cancelled due to emergency cases needing to be done.

While elective day surgery cases would not be affected by emergency surgical cases, the cancellation for obstetric emergencies would continue.

Refer to the *Clinical Support Services – ICU / HDU* section below for more information.

Intensive Care Unit / High Dependency Unit

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
ICU / HDU	6	6	5	5	4	4	Stand alone HDU	SSU within ED for stabilisation

Mersey Community Hospital

The change of the classification HDU at MCH has merit in that the coverage of that unit from a medical point of view is at the moment inadequate, but only if there is significant improvement in the ability to transfer sick patients in a timely fashion. Presently, there are patients in the system that are identified as needing transfer / retrieval who deteriorate while waiting long periods for that transfer to occur.

HDU at MCH could be re-classified to provide higher level nursing care for suitable patients, which is essentially its current functionality. This would then be classed as a close observation unit.

Longer term changes to the lesser acuity medical inpatient capacity at MCH will present a great challenge. Issues around bed capacity at NWRH and LGH will need to be addressed as there are many times currently when beds are not available for patient transfer.

North West Regional Hospital

We note there is no mention of criteria for HDU within the White Paper.

The Level 4 ICU at the NWRH currently works closely with the HDU using the same nursing pool. Any changes in the model of care will require a review of clinical workforce resourcing.

In this regard, the delineation model states:

- **Service requirements:**
  There has been some conjecture of having a time limit on the service. This should be reliant on the patient's condition. Some may be able to stay longer than 36 hours as complexity may be being adequately managed.

  ICUs require access to 24 / 7 pathology and radiology services.

  A Level 4 ICU has level 4 pathology services but level 4 pathology criteria does not state 24 / 7, this is at a level 5.

- **Workforce requirements**
  Recruitment of medical staff in this area is particularly difficult. As case load from a College of Intensive Care Medicine perspective is level 1.

  NWRH ICU is currently supported by the anaesthetic department to provide 24 / 7 cover.

  In addition to the attending specialist, at least one on-site registered medical practitioner with appropriate level of experiences, airway and ALS skills, should be rostered for the unit and immediately available at all times to attend the unit.

  As of 2016 the anaesthetic registrar training program will not be able to 'count' the 13 weeks in ICU as part of their training program. Recruitment to a medical model of level 4 may be difficult in the environment of reducing complexity. Similarly nursing staff in ratios of required qualifications may not be maintained.

Core Clinical Services

Trauma

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Trauma Services	5/6	6	5	5	4	4	3	3

Mersey Community Hospital

Given the geographical location of MCH, it would seem more logical and safer to consider LGH as the main referral hospital for MCH rather than NWRH and this would be consistent with most of the key objectives of the health reforms.

This should include emergency ambulance presentations where clinical criteria requires transfer to a higher level emergency department, as patients who require care in a Level 5 or Level 6 hospital will be in the

most appropriate hospital and avoid a second ambulance transfer from NWRH at the western end of the north-west coast.

North West Regional Hospital

Delineation model is appropriate. Trauma patients do increase complexity of care and are seen as a vital component on maintaining skills within teams particularly ED and ICU staff. The transport system will need to be resourced to support safely.

The terminology 'General surgeon on site and on call 24 hours' needs clarification. The need for a surgeon physically on site 24 / 7 is probably not essential, but the capability of a call in and appropriate response time is necessary. As this is not currently a requirement and some surgeons may not live within 30 minutes this will take time to implement. Current medical awards do not include 'response time' when on call.

There may be industrial relations implications in the short term.

General Medicine

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
General Medicine	6	6	6	6	5	5	Level 4 capability but some service provided at Level 5 & 6	4

North West Regional Hospital

The NWRH medical ward has 31 beds with limited ability to increase this number as it is situated between the rehab and surgical ward. It currently operates at a consistently high occupancy rate (85-90%). The impact of all acute admissions going to NWRH would require further analysis of the number of beds required to meet the needs of the region.

Further definition of subacute patients, suitable for MCH admission would also require review.

Acute patients become subacute and vice versa throughout their admission. At present the transfer of patients from one facility to another in a timely and appropriate manner requires acceptance by a consultant at the accepting hospital, bed availability, appropriate transport, and patient or client agreement. All these are common barriers at present and a time consuming process. Detailed mapping of this process and clear movement parameters would need to be established to ensure a smooth transition. Also the public acceptance that this would occur may be an issue, as many now refuse to be transferred back.

The proposal that advice and consultation from networked sites will be more readily available and a smoother transition for patient care, at this stage, presents barriers with specialist acceptance. This pathway needs to be developed to ensure bed availability and suitable transports are available.

Integrated Cancer Services

North West Regional Hospital

We were surprised by statements made within the exposure draft White Paper about the present delivery of cancer services in the region.

The THO ***has not*** had difficulty recruiting a Medical Oncologist as it has had a contractual arrangement in place with a private health provider to provide medical oncology services for over four years. The contract has provided clinical stability and a fulltime medical oncologist who is available 24 / 7.

This contract was developed to bridge cancer services in the north-west while the North West Regional Cancer Centre was being built. The Centre is expected to be fully operational by 2016 and at this point in time, we are unaware of any safety concerns about the delivery of this service.

Nor has the THO-North West had difficulty recruiting nursing and allied health staff and the service generally continues to work effectively and is well supported by medical and nursing staff. In regards to complex cases, services are provided and supported by THO-North and THO-South.

We understand an integrated cancer service model-of-care is presently being considered and it is important that the model-of-care ensure sufficient medical, nursing and allied health staff, continue to be available onsite 24 / 7 at both LGH and NWRH.

Endocrinology

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Endocrinology	6	6	5	5	4	Change from 4 to 5	3	3

North West Regional Hospital

In relation to the Endocrinology delineation model for Tasmania's north-west – it is proposed that the service provided from the NWRH should be altered to a Level 5.

In ***support*** of this the following information is provided.

The Australian Institute of Health and Welfare (AIHW) report *Australian Hospital Statistics 2004-2005* indicated that Tasmania had the third highest rate of preventable hospitalisations for diabetes complications in Australia. THO–North West had the highest rate of preventable admissions for diabetes in Tasmania and nationally. This AIHW 2005 report identified that this region accounted for 40.2% of these occasions and with the northern half of Tasmania combined 76.3%. Whilst resources for diabetes in the north-west have been increased since this paper – this paper has not been updated and it is submitted that a multidisciplinary team inclusive of a fulltime endocrinologist, dietitian, podiatrist and psychologist are required to target reduction in this avoidable admission rate. Strong relationships between the Diabetes Centre and TML / General Practice already exist and have been developed since that time to support the provision of quality primary care.

Not only is diabetes more common in the north or north-west, but the NADC Diabetes Centres in this region manages a high volume of moderate to high acuity cases. Many cases of type 1 diabetes have multiple other co-morbidities that may include one or several of the following; end stage renal failure, severe exocrine deficiencies, neoplasia, cystic fibrosis, cancer of pancreas, pancreatitis, coeliac disease, endocrinenopathies (thyroid, Cushings, Addison's disease), depression, gastroparesis, hypo unawareness and neuropathies.

Poorly managed diabetes and obesity is the leading cause of other co-morbidities that exist at high levels here in the north-west of Tasmania; for example, cardiovascular disease (up to 50%), end stage renal disease (> 50%), cancer types including; oesophagus, pancreas, colon and rectum, breast (after menopause), endometrium (lining of the uterus), kidney, thyroid and gallbladder and a major risk factor for other chronic conditions such as hypertension, cardiovascular disease, dyslipidaemia and arthritis. Thus, good clinical care in these patient groups is vital in not only the management of diabetes but in the reduction of risk factors for other co-morbidities.

A study of the foot-health of adults with diabetes in regional Australia (the PODFAR study - a collaboration with La Trobe University, University of Tasmania and public podiatry services; unpublished data) has demonstrated that residents of the north-west of Tasmania have triple the odds of foot morbidity (OR 3.21, 95%CI 2.23-4.83) than comparable patients in regional Victoria. It should be noted that foot complications are a very frequent cause of potentially preventable hospital admission – the role of the specialist podiatrist and dietitian, and endocrinologist in High Risk Foot Clinics is imperative.

There is next to no access to private endocrinologists and allied health professionals specialising in diabetes in the north or north-west of Tasmania. Socioeconomic standing of the population of the north-west generally would make review by the private sector a non-viable option and thus they will miss out on necessary care provision.

People living outside major cities are more likely to have diabetes than those living within major cities. Thus, in the northern half (north or north-west) of Tasmania, there are 1200 (13905 vs 12704) more cases of diabetes than the south of the state; predominantly more type 2 diabetes.

In forward planning for services that the exposure draft White Paper indicate will be increased in the north-west and, that, we know will increase demand on specialised multidisciplinary diabetes services for the provision of appropriate diabetes management to ensure safe quality care, hospital aversion and or decreasing LOS (ie state-wide day surgery at the MCH and growth of cancer services in the north-west). An example of this specialised diabetes management; many oncology patients are placed onto high dose Dexamethasone for the management of symptoms that leads to significant hyperglycaemia which in turn leads to preventable admissions.

Gastroenterology Services

Increased investment in gastroenterology services for endoscopies is required due to increased patient demand from a local and statewide perspective including the Commonwealth national bowel screening program requirements.

Infectious Disease

Infection prevention and control is identified as being required for Level 4, 5 and 6 hospitals. We would ***recommend*** Level 3 hospitals also be required to have 'on-site infection prevention and control service'.

Factors to support this would include:

- Ability for the hospital to achieve compliance with Standard 3.
- Locally available infection prevention and control resource
- Delivery of ongoing infection prevention and control education.
- Development of site specific infection prevention and control procedures, in line with state wide policies. Development of policies and procedures in absence of state procedure.
- Daily surveillance activities / audits
- Maintenance of ongoing infection prevention and control surveillance programmes. Preparation of data for state wide collation.
- Apparent lack of capacity for neighbouring level 4 and level 5 hospitals to provide a full range of infection prevention and control activities supports (education, resource provision and surveillance) to our site.

In regards to the type of rooms at each facility, we would ask that you consider including the availability of a negative pressure isolation room in hospital emergency departments. To enable safe accommodation of patients - with suspected transmissible diseases - prior to the transfer of said patients.

The role of the infection prevention and control nurse within the Primary Health Services is to support and educate staff to minimise the risk of clients / patients / residents in acquiring preventable healthcare associated infections and to ensure staff are able to manage infections effectively when they do occur using evidence based practice.

The below dot points help to support this statement.

- Acute Rural Inpatient sites are able to care for patients with infectious diseases
- Delivery and administration of home-based therapies to clients requiring intravenous antibiotic therapy – all rural sites and Community Health including Burnie Acute Care at Home (BACH).

There is a dedicated Primary Health Infection Control CNC available to provide advice to staff working in the rural sites / community health / community services / community mental health services as required.

Acute Stroke Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Acute Stroke Services	6	6	5	5	4	4	4	Change from 3 to 4

We note the service level proposal for NWRH to remain at a Level 4 with potential consolidation of stroke services and transfer of patients from MCH to NWRH. We note in the acute stroke services

section of the delineation paper a number of contradicting points regarding stroke units as geographically designated units, and geographically discrete units which leads to our confusion. For example on page 83 level 4 services do not have a dedicated stroke unit however the definition on page 82 recognises that smaller hospitals consider stroke services adhering to stroke unit criteria on geographically discrete units which suggests we would become a stroke unit.

We note on page 84 that a primary stroke centre must receive over 100 stroke admissions each year. If NWRH and MCH consolidate stroke services they will have 160 admissions per year minimum, therefore by this definition they would be considered a primary stroke centre and therefore a Level 5. We find these contradicting descriptions confusing. We suggest that if NWRH is to remain a Level 4 that the Level 4 descriptor includes becoming a designated stroke unit or alternatively the proposal long term is for the NWRH to become a Level 5 and have a designated stroke unit once it consolidates services between MCH and NWRH.

In regards to the Level 5 service requirements, we note significant statewide challenges in accessing driving assessments. North-west patients can only access driving assessments if they pay privately as they have been excluded from other public services. Therefore, we ***recommend*** this be a Level 5 or Level 6 responsibility to provide this for lower level services.

Rheumatology and Pain Management

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Rheumatology and Pain Management	6	6	4	5	Change from No Level to 4	4	Change from No Level to 4	Change from No Level to 4

North West Regional Hospital

We note the exposure draft White Paper proposes a Level 4 service for NWRH which means the service would no longer provide inpatient services. Currently both NWRH and MCH provide inpatient services through anaesthetists (with special interest and or training) and nurses (with a portfolio related to acute pain).

Any contemporary practice for pain management must have an inpatient component as many chronic pain cases commence from poor management in the acute setting.

We ***recommend*** a change that includes increased linkage between the acute pain nurses and doctors at NWRH and MCH to provide better service through consultation and education for inpatients.

Surgical Services

More information is required to enable us to respond to a number of items including those below:

- Is MCH proposed to be an elective day stay where people are discharged on the same day home or is MCH proposed to include a 23 hour short-stay facility which may mean people stay overnight?

- What is the intent as this will determine patient flow and bed requirements?

- Similarly to the above, has modelling been undertaken to support the proposal that NWRH do all acute-emergency surgery? As it is likely utilisation of acute beds at the hospital will increase significantly should this occur and additional funding would be required.

- In reference to Page 39 of the exposure draft White Paper re 'An integrated northern surgical service managed from the LGH…' what does this mean?

General Surgery

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
General Surgery	6	6	5	5	Level 4 capability but some surgery performed at Levels 5 & 6	4	Level 4 capability but some surgery performed at Levels 5 & 6	3

North West Regional Hospital

Loss of high complex patients from NWRH may create issues of attraction of surgeons who are prepared to do low-medium complexity and not travel for complex cases at other sites. The hospital provides a trauma service at present which includes presentations as an acute and or emergency case of medium-high complexity. It would be difficult to maintain a surgeon's competency to respond to cases, if they are not being exposed to complexity as per normal practice.

Loss of high complex patients could also mean a decrease in revenue when related to National Efficient Price / Cost for Australian public hospital services. Although an increased throughput of lower acuity cases may offset this. THO-North West has seen no modelling to consider the revenue implications to the hospital.

NWRH has the capacity to safely provide in the **operating theatre**, complexity Level 4 and some select Level 5 surgical procedures which can be supported both clinically and with appropriate resources to ensure skill maintenance across nursing and medical staff. This enhances capability in the longer term for emergency patients.

Urology services being provided at NWRH would incur additional equipment expenses, in particular for endoscopic procedures. This service is likely to be best provided within the MCH where the appropriate equipment is already available.

With new introduction of surgical specialities the need for **pre and post-operative consultation** would also increase. NWRH has limited clinic space available as the present service was built twenty years ago for less demand. Should service capacity increase investment to build clinical space will be required.

In regard to efficiency, it should be noted that **day cases** fill gaps in surgical lists to enable efficiency in time allocations. NWRH would still need to have day cases for this reason.

Twenty three (23) hour surgery is an acute model-of-care and this should be considered at NWRH to improve efficiency and cost effectiveness. It also has acute beds available if the patient fails the 23 hour length of stay.

Ear, Nose and Throat

We ***recommend*** that physiotherapy and occupational therapy are not required for the majority of ENT patients and therefore should be listed as 'access to' in the delineation levels and not included in the definition.

Mersey Community Hospital

It is proposed that MCH be a Level 3 service. Presently, MCH does not have onsite audiology and therefore we ***recommend*** changing the service description to 'access to visiting service'.

North West Regional Hospital

It is proposed that NWRH be a Level 4 service. Presently, one ENT surgeon is available 24 / 7 and going forward this model of care is not sustainable or safe.

Gynaecology Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Gynaecology Services	6	6	5	5	4	4	Level 3 capability but some surgery performed at Level 4	3

North West Regional Hospital

Should only day patients occur at NWRH, we may have difficulty recruiting sufficiently qualified clinical staff with Fellow of the Royal Australian College of Obstetrics and Gynaecology (FRACOG) qualification. Presently, this workforce is generally overseas trained and would not meet the workforce definition as prescribed in the current role delineation model.

Ophthalmology

North West Regional Hospital

Ophthalmology Services are delivered to NWRH through a Contract for Service with the North West Private Hospital. It should be noted current capability includes service requirements and workforce requirement performed at Level 5 as per the delineation model.

Oral Health Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Oral Health Services	5*	5	3	4	Change from Level 3 to 4	Change from Level 3 to 4	4	4

Level 4 Oral Health Services are ***presently*** provided to NWRH and MCH through Oral Health Services Tasmania as a statewide delivered service. As per the delineation model service description, the level of service for patients is expected to remain unchanged.

It should be noted that an oral health specialist undertakes surgery at MCH one day each month. Should this cease, additional funding for patient accommodation and travel would be required.

Orthopaedic Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Orthopaedic Services	6	6	5	5	4	4	3	3

North West Regional Hospital

We ***recommend*** the Orthopaedic Services service delineation model service requirements be amended.

It is proposed that NWRH be delineated as a Level 4 site. However NWRH is currently not an accredited orthopaedic surgical training site for a number of reasons, therefore changes to ensure sufficient caseload and continuity of surgical funding are required.

Plastics and Reconstructive Surgery

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Plastics and Reconstructive Surgery	5*	5	5	5	Change from Level 4 to No Level	4	Change from Level 3 to No Level	3

NWRH does not deliver Level 4 plastic and reconstructive surgery. MCH does not deliver Level 3 plastic and reconstructive surgery. This is because and as per the delineation model service requirements, plastic surgeons do not visit NWRH or MCH presently.

Urology Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Urology Services	6	6	6	6	No Level	Change from Level 4 to No Level	Change from No Level to 4	4

Level 4 Urology Services are ***already*** provided to north-west patients at MCH through THO-North as a statewide delivered service. It is unclear why the service should be duplicated at NWRH. Therefore we ***recommend*** a discussion is had with THO-North to ensure capacity is sufficient and safe to offer this service across both sites.

Consideration should also be given to the Community Continence Service (CCS) provision. Although, CCS is currently HACC funded, there is a definite need for state funded community continence in post-acute care and also to reduce avoidable admissions to ED.

Vascular Surgery Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Vascular Surgery Services	6	6	6	6	Change from Level 3 to 2	Change from Level 3 to 2	Change from No Level to 2	2

Mersey Community Hospital

Level 2 Vascular Surgery Services are ***presently*** provided to MCH north-west patients through THO-South as a statewide delivered service. As per the delineation model service description, the level of service for patients would remain unchanged.

North West Regional Hospital

We believe that NWRH is also a Level 2 Vascular Surgery Service, performed only by general surgeons rather than through visiting vascular surgeon from THO-South.

Neonatology Service

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Neonatology Services	6	6	5	5	4	(4)	3	(4)

North West Regional Hospital

The WACS CAG response to the Green Paper supported the idea of not changing the gestational age cut-offs for births, i.e. current gestational limits: NWRH at 32 weeks and MCH at 34 weeks. We concur with this proposal.

Currently, we have good outcomes and changing these limits will negatively impact the local service if patients have to be transferred intrastate, in the following ways:

- Deskilling (and loss) of neonatal staff, i.e. doctors and nurses
- Lack of access to services for patients and their families, especially for those from the west coast, will unfortunately negatively impact the most vulnerable part of communities in the north-west
- Lead to recruitment difficulties of doctors (which is already a problem)
- Training opportunities of registrars and junior doctors, and nurses.
- Increased demand on transport services.

Our outcomes for patients born at 32-34 weeks are comparable to that of RHH and LGH. Therefore, it is highly likely that we will be improving the quality and safety of healthcare for our neonates.

Paediatric Services

North West Regional Hospital

Firstly, it is difficult and premature to provide an adequate response to this paper and its impact on the provision of services and patient care, without having knowledge of detailed workforce allocations.

The delineation model for paediatric medicine is appropriate for both MCH and NWRH. The paediatric unit at NWRH functions at Level 4, similarly to the LGH, except for the level of some supportive services.

It is worthwhile mentioning that the level of acuity of cases will not have a significant bearing on our service, as the vast majority of our workload involves chronic and outpatient care.

The NWRH paediatric department offers a number of additional (unique) services: asthma / allergy clinic (also nurse led clinic) / diabetic clinic – (multidisciplinary) / continence clinic / outreach service to remote areas / telehealth service / CF clinic (multidisciplinary). We are unsure whether these can still be offered as Level 3.

Palliative Care Services

North West Regional Hospital

In regards to the White Paper clinical service profile for Palliative Care Services, it should be noted that there is not a defined or dedicated Level 4 Palliative Care Service at the NWRH rather it is a Level 3 service which has access to two dedicated inpatient specialist palliative beds at NWRH.

The admission diagnosis is not always reflective of palliative care and needs strengthening. Some will be admitted as acute as they are in an acute phase of their disease and require symptom management. This will need some further discussion on whether they will come to NWRH.

Many acute patients become palliative patients; are we to transfer these patients then? To transfer these patients between hospitals in the end stages of life is often a delicate process in timing and family wishes. The palliative patients can have many complex and unstable conditions so difficult to classify them as subacute patients always. This area needs consultative discussion with community involvement. There may also need to be work done to differentiate between palliative and palliating patients (usually end stage chronic disease).

In regards to the Page 181 of the delineation paper, we would recommend under Level 3 Palliative Care Services requirements that access to an Allied Health OT and Physio be added.

Rehabilitation Medicine Services

We are concerned about the word rehabilitation being used singularly rather than the word being aligned with its associated clinical speciality. Common use of the term 'Rehabilitation Service' is usually associated with a combination of stroke, orthopaedic and deconditioning issues.

Further clarification of the definition of rehabilitation is also required in conjunction with a review of the definition of geriatric services as it would appear there is some confusion regarding the different types of rehabilitation / geriatric services that can be provided.

We *absolutely disagree* with use of the word "medicine" in the title for "Rehabilitation Medicine Services". Rehabilitation as a speciality service is much more than many others services, are team based approach with strong service provision from allied health and nursing. This also relates to the team led models – these could interchangeably be both nursing and allied health and not "nursing" specific. More appropriately they should be referred to as "team led models".

In making the assumption the definition of the word - rehabilitation - within the exposure draft White Paper is - Rehabilitation Service. We *strongly disagree* with the current and proposed ratings of rehabilitation services in the north-west.

According to the delineation model, a minimum of a Level 5 service will be called a designated rehab unit. NWRH has had a designated rehab unit and has employed a rehabilitation consultant since April 2014 and April 2015 respectively. Therefore the unit at NWRH ***should be*** listed as a Level 4 or Level 5 based on the delineation model definitions and ***not as*** a Level 3.

We note with concern the proposed level of service for rehabilitation at the MCH as a Level 4 in contrast to the Level 3 rating at the NWRH. In terms of recruitment and retention of a rehabilitation consultant we would assume that the levels of rehab between NWRH and MCH would be the same as they will be run on a regional basis and therefore by the same rehabilitation consultant. The same clinical processes

will exist at both facilities with a possible difference in client group. If the rehabilitation consultant works on a regional basis for the north-west then a minimum of a Level 4 should be achieved across the region.

Geriatric Services

We note in the clinical services profile a proposed level of 4 at MCH and 3 at NWRH and we welcome an increase in services for our older population.

We do request some clarification of the definition of 'inpatient subacute geriatric beds' and 'GEM units'. These two services are both considered to be subacute. If this could be clarified it would be beneficial.

Mental Health Services (MHS)

The recognition that Rethink-Mental Health is the key driver for the development of mental health services in Tasmania is appreciated and supported. In recognition of this, the comments provided relate to inpatient services only.

Mental Health Inpatient Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Mental Health Inpatient Services	6	6	5	5	5	5	3	3

The mental health inpatient unit in the north-west is a Level 5 service as outlined in the delineation model.

It is proposed that the mental health inpatient unit in the North is developed to a Level 6 and plans have been developed to have a psychiatric intensive care unit. Transport of very agitated patients to Hobart is logistically difficult from a patient, staffing, family and transport service perspective.

The skill mix of psychiatric intensive care units differs from an inpatient unit in intensity of staffing ratio, and therefore limited staff expertise is not a factor prohibiting this development.

The high care units that exist in both north and north-west are not mentioned. However, if a psychiatric intensive care unit was developed in the north, these could potentially be removed from the model of care.

A similar model of child and adolescent should be developed creating more accessible services for the north and south.

Child and Adolescent Mental Health Acute Inpatient

Reference:	RHH	RHH	LGH	LGH	NWRH	NWRH	MCH	MCH

White Paper	Current	Proposed	Present	Proposed	Current	Proposed	Current	Proposed
CAMH Acute Inpatient Services	4	5	3	5	3	3	No Level	No Level

Child and Adolescent Mental Health Acute Inpatient Services at NWRH is a Level 3 service as outlined in the delineation model.

The proposal to establish an adolescent unit as part of the redevelopment of RHH is welcomed and will be of significant benefit to children and adolescents and their families in the north and north-west.

The participation of families in the treatment of children and adolescents is essential and it is assumed that planning for this development will include options in relation to accommodation and travel to ensure families can still be an integral component of the treatment and discharge planning.

Similarly the use of technology such as videoconferencing with the community CAHMS team in the north-west will be essential for a smooth transition back of patients back to community care.

Alcohol and Drug Services:

Enhancement of alcohol and drug services is welcomed and very much needed in the north-west.

Inpatient detoxification needs to be reviewed as part of this development. The management of patients who present at emergency departments (often expressing suicidal ideation while intoxicated), creates a number of issues for services at NWRH. A safe place for these patients to be monitored overnight is needed, along with active intervention from alcohol and drug services.

Integration of alcohol and drug services and mental health services has been raised during discussions in Rethink-Mental Health. The development of services in the north-west should encompass principles of integration.

Subacute / Rehabilitation services

The need for a subacute (step up / step down) facility in the north-west has been identified. It does not however necessarily need to be provided within a hospital setting. An ambulatory rehabilitation model of care could be incorporated.

Psychiatric Services for Older People

The delineation model ***should include*** psychiatric inpatient services for older people. The proportion of the population over 65 years of age will increase significantly, and hospital services should clearly identify services provided. It is noted that Geriatric Services require enhancement in the north-west. A similar case can be argued for Psychiatric Services for Older People.

It is important to recognise that elderly patients are currently admitted to units such as Spencer Clinic Inpatient Unit. The clear delineation of psychiatric services for older people will inform facility planning for

example ensuring any redevelopment of current mental health inpatient units includes the creation of dedicated areas that are designed to cater for the needs of this population group.

Palliative Care Services

Reference: White Paper	RHH Current	RHH Proposed	LGH Present	LGH Proposed	NWRH Current	NWRH Proposed	MCH Current	MCH Proposed
Palliative Care Services	4***	4**	4	4	Change from 4 to 3	3	No Level	3

Palliative care is embedded in a primary health care approach. It is difficult to apply the service delivery model to the delineation model descriptors. Adequate and appropriate resources (e.g. Health professionals, carers, equipment and education) are required to provide sustainable care to community palliative clients and to support their families / carers

Many people with a life limiting illness may choose to remain at home for end of life care, and in the majority of cases they are supported by enthusiastic and loving families and carers. Regardless of the amount of support made available to clients / families and carers, the constant pressure of providing ongoing care to a loved one often results in family / carer fatigue and "burnout". This crisis may necessitate the client being admitted to hospital, the exact opposite situation that was initially chosen by the client and family/carer. The availability of hospice care would prevent these situations from occurring, and would provide an environment where families / carers are able to spend quality time with a loved one, without feeling the pressure / burden of providing 24 hour care / support. Others may very well choose to die in the hospital setting for various reasons and this too should be respected.

Within the White Paper, the term Palliative Care Service is used interchangeably. In some cases it refers to the three dedicated specialist services and generically to refer to ALL palliative care providers. This causes confusion in the interpretation of the delineation model. We ***recommend*** that this be clarified and well defined on what is meant by provision of palliative care service.

Workforce

Clinical workforce

The move to the THS provides for an opportune time to consider the recruitment, retention and development strategies of our clinical workforce. One of the key focuses of this opportunity should involve endeavouring to move away from a transient, almost temporary clinical workforce in some areas, to a workforce planning strategy that involves engaging appropriate clinicians on a more permanent employment basis across all areas within THS.

A move in this direction would have numerous benefits such as, lower salary (lower locum dependence) and recruitment costs, potentially higher quality and safer patient care, greater stability in the clinical workforce and better training opportunities for junior doctors.

Often we employ clinicians on a fixed term basis, say for three (3) years then we regularly roll their contract over for another three (3) years and so on, this gives little confidence or security to the clinician and the service, and we incur administrative costs each time we do this.

It should be noted that this is not simply a matter of providing for a more permanent type of employment, but rather consideration given to a holistic approach to make working in all areas of THS an attractive proposition for clinicians so that both metro and regional communities enjoy the benefits of stable, good quality and safe health care.

Specialists nurses

A new model of care could be considered for some clinical specialities such as dementia, neurological, spinal and clinical coordinators to contemporise patient centred care.

Chronic Obstructive Pulmonary Disease Clinical Coordinator (Specialist Nurse)
There would be benefits in having a clinical coordinator located within ED / inpatient wards / community health centre to include;

- Individual assistance to help navigate the health system
- medication review and self-management techniques to reduce medication errors
- coordination and education about disease specific care and management techniques
- Prevent readmissions due to anxiety / lack of understanding / of discharge requirements.

The Healthy Tasmania report suggests empowering, connecting and enabling access. This would be achieved by clinical coordinators who educate and promote self-management of chronic diseases.

As the north-west coast is isolated in regards to medical specialist clinics, we need to push nurse-led clinics, which are supported by medical specialists, accessible by phone / VC / standing orders. We should role model what is currently being achieved by specialist nurse clinics such as respiratory, neurological to name a few. This will keep clients in the Level 1-3 as per the delineation paper.

Other Support Services

eHealth including Telehealth

Leading principles behind the exposure paper are access to better care, high quality health services to be only delivered where appropriate support services are available, and less duplication.

The achievement of these principles will have to be underpinned not only by improved transportation and accommodation support, but also by the harnessing of Telehealth and improvement of the electronic Health Information Systems, as outlined in the THO-North West Connected Care Strategic Plan.

The centre piece of the strategic plan is the Connected Care Platform as outlined in the DHHS Connected Care Strategy. This platform will underpin an increasingly accessible, equitable and sustainable Tasmanian

Health Service system by enabling and supporting new and emerging models of care, based on the provision of high quality, longitudinal care consumer centric information.

As much of the Connected Care Strategy hasn't been funded yet, the implementation thereof is moving very slowly. A submission for funding has been made to the Tasmanian Health Assistance Package.

The THO has been harnessing Telehealth to its rural facilities in King Island and the West Coast, for clinical applications for some time through case conferences and specialist consults. Many of these sites also have the ability to dial through to the NWRH emergency department in case of an emergency. Specialist paediatric consults also occur with the Royal Melbourne Children's Hospital via Telehealth.

Although the THO would like to provide many more specialist consultations through Telehealth at its rural facilities, it is unable to do so as it is not funded to provide the clinical resources required to support Telehealth services. For example a nurse is required to be present with a patient at a remote site, which does not attract any financial reimbursement. Scheduling and organising of clinical consultations requires additional administrative support.

It should be noted THO-North West conducted a Telehealth Pilot Project between November 2012 and October 2013. The pilot identified that if Telehealth services was appropriately resourced and strategically planned, Telehealth consultations could be delivered to the mutual benefit of all stakeholders.

Infrastructure

The ongoing role of MCH for day surgery, endoscopy and future role expansion will require capital investment to render the facility fit for purpose in order to achieve cost and resource efficiencies that are hindered by the geographical layout of existing infrastructure. Similar consideration exist for future planned service profiles, particularly associated with geriatric care, palliative care, slow stream rehabilitation, ambulatory rehabilitation, alcohol and drug rehabilitation etc. The existing facility will require some extensive capital works to ensure capacity to provide these services. Clinical workforce skill-mix and experience will require significant change in order to ensure that MCH is able to provide enhanced and amended service provision that will requirement investment in staff development and training.

Ends.