

Women's, Children's & Adolescents Services CAG

Paediatric Medicine

Response to Green Paper

The Paediatric Specialists as co-opted members of the WACs CAG are pleased to have this opportunity to provide this response to the Government's Green Paper.

The CAG acknowledges that the proposed framework is designed to examine the acute hospital based tertiary service, thus the outpatient and community services are not extensively discussed in this response. However, management of acute paediatric issues makes up a small percentage of the overall paediatric health care workload. Management of chronic conditions including developmental and behavioural issues, and preventative medicine makes up the bulk of paediatric healthcare presentations.

The location of delivery of these services (outpatient clinics, private rooms, community health services) reflects the availability of services in the community from which the patient presents. The availability or otherwise of private paediatricians, bulk-billing services, and other community resources such as parenting centres, school psychologists and community mental health services therefore will need to be mentioned in this CAG response.

The Tasmanian Role Delineation Framework (TRDF) does not consider management of paediatric chronic conditions. Furthermore, effective paediatric care involves the use of multidisciplinary teams, including medical, nursing, allied health, child protection, mental health and education professionals. The Tasmanian role delineation framework is not well structured to reflect this style of practice, so recommendations for modification of that document have been included.

Service Profile

Current Service Overview

Based on the Service Descriptions provided in the draft TRDF the CAG believes that Tasmanian Hospitals are providing the following levels of paediatric medical service:

- Royal Hobart Hospital – Level 5
- Launceston General Hospital – Level 4
- North West Regional Hospital – Level 3
- Mersey Community Hospital – Level 1

Proposed Role Delineation for Paediatric Medicine

- Royal Hobart Hospital – Level 5
- Launceston General Hospital – Level 4
- North West Regional Hospital – Level 3
- Mersey Community Hospital – Level 2

The MCH needs to be delineated as a Level 2 service to allow for paediatric patients to remain in the Short Stay Unit within Emergency Department (only) for up to 24 hours.

Proposed changes to the Paediatric Medicine Role Delineation are listed below and have been included in the document (Attachment I)

South

- The RHH currently performs as a Level 5 hospital.
 - It exceeds some criteria for a Level 5 by supplying some subspecialty services, but falls short of a Level 5 due to a lack of allied health staff, the absence of an adolescent unit, restriction of some state-wide services due to the 3 THO business model, poor education facilities for patients, and staffing inadequacies.
- The population of the Southern region and the RHH's role as a referral centre for some adult and paediatric medical and surgical specialties justifies the need for the services provided at this location.

Services

- RHH is a teaching unit of the University of Tasmania, providing training to medical, nursing, paramedic and social work students.
- Graduate courses in paediatric nursing and neonatal intensive care nursing are offered on site.
- A paediatric sexual assault care service provides acute (out of hours) and non-acute services for cases of sexual abuse or rape in people under the age of 17 years. Cover is offered 24 hours a day 7 days a week.
- Non-sexual child abuse is managed by the general paediatrician on-call with the assistance of the social worker and co-located child protection worker (Child Protection Liaison Officer).
- The hospital based community paediatrician provides clinical service in the south and has a statewide role in coordination of paediatric policy regarding paediatric sexual assault, child abuse and children living in state care (Out Of Home Care service).

Inpatient Services:

- 25 beds including 8 single rooms. There is no secure facility for adolescents with severe mental health problems causing deregulated behaviour. No true separation of adolescents and babies.
- On-site NPICU
- On-site paediatric surgeons
- Anaesthetists with subspecialty training in paediatric anaesthesia
- Inpatient CAMHS team

Emergency Services:

- 4 designated beds in a separate area within the emergency department for paediatric presentations

Outpatient Services

- Provided by staff specialists and local VMOs
- General paediatrics, neonatal follow-up (high-risk neonates), cystic fibrosis, respiratory, diabetes, behavioural medicine, developmental, continence, allergy, child protection and child sexual assault.
- Paediatric neurology, oncology, eating disorders and child protection all provide some state-wide services

Clinics provided by visiting interstate specialists:

- Paediatric cardiology, endocrinology, gastroenterology, clinical genetics
- Paediatric rehabilitation- provided by short-term visiting specialist and senior registrar in subspecialty training. Local trainee will assume consultant role once fully accredited.

Outreach clinics

- Geeveston and Bridgewater visited by community team

Current Staffing profile:

- RHH has 6 full time staff specialist paediatricians providing on-site services and after hours on call.
 - This is in addition to the staff specialists servicing the Neonatal and Paediatric ICU (NPICU).
- All paediatricians are qualified and recognised as general paediatricians. All staff specialists have a sub-speciality interest and provide some subspecialty clinics in addition to general paediatric duties.
- Of the six staff paediatricians:
 - 1 is a recognised paediatric oncologist
 - 1 a paediatric neurologist
 - 2 are recognised community / forensic physicians; and
 - 1 is a recognised clinical pharmacologist.
- One senior registrar is undertaking extra training in rehabilitation medicine in order to provide a local service for children with severe disability in the near future.
- Registrar support is provided by:
 - 11 FTE general paediatric registrars
 - 2 neonatal ICU senior registrars
 - 1 general paediatric senior registrar; and
 - 3 community senior registrars.
- Funding for 3 senior registrar positions is via the federal SPPT program and may not be ongoing long term. There is 24 hour registrar on site cover.
- There are 7 resident medical officers, 3 of whom are senior, who provide 24 hour support to the registrars.
- Currently 2 registrars are recruited to Hobart and placed in Burnie and Launceston on rotation.
- An inpatient CAMHS team comprising of:

- 1 child and adolescent psychiatrist, a child and adolescent mental health nurse, a psychiatry registrar and mental health allied health professional are available within the hospital during hours.
- This is an essential support service for inpatients and acute presentations to the emergency department. (*Please refer to CAMHS CAG paper*).
- A number of paediatricians provide paediatric outpatient care in the community (one full-time and 7 part-time). Some of these practitioners also work as VMO staff on the paediatric ward, the outpatient clinics, or within the paediatric sexual assault care service (PSAC).
- These practitioners see a large number of patients who would otherwise need to be seen in the hospital outpatient department. The assistance of these VMOs is also necessary to maintain difficult rosters such as PSAC. VMOs are encouraged to stay and practice in the region by the opportunities for educational and peer support provided by VMO appointments for one or two sessions per week.
- Paediatric consults in the community occur within these private practices and involve out of pocket expenses for patients in the majority of cases, and are thus out of reach for the more disadvantaged members of the community.
- RHH provides ICU facilities and care for babies and children, and neonatal and paediatric surgical services (*please see attached CAG documents for further information on Neonatal Services and Paediatric Surgical Services*.)

North

- Launceston General Hospital (LGH) currently functions as a level 4 hospital. This is appropriate for the major regional hospital providing outreach to the region and acting as a referral base for the North West.
 - The LGH exceeds some criteria for Paediatric level 4 services but falls short of level 5 services as it does not have NICU / PICU services.
- The LGH is a teaching unit of the University of Tasmania and provides training to medical, nursing and social work students.
- LGH has 4 fulltime Staff Specialist Paediatricians supported by 5.5 FTE registrars and 3 residents..
- 24hour on-site registrar cover.
- There are no private Paediatricians within the community.

Inpatient Services

- 24 bed Paediatric ward and
- 9 bed Level 5 Special Care nursery (accepts from 30 weeks gestation).

Outpatients Services

- Over 120 general paediatric outpatient appointments offered each week. There are significant waiting times for appointments.
- Outreach clinics are provided to George Town, Scottsdale and Tasmanian Aboriginal Centre (TAC).
- The LGH hosts outreach clinics from external providers including:
 - Paediatric Neurology - RHH – 4 x 1 day visits per year
 - Paediatric Oncology – RHH – 4 x 1 day visits per year
 - Paediatric Surgery – RHH – 6 x 1 day visits per year

Clinics provided by visiting interstate specialists:

1. Paediatric Cardiology - RCH Melbourne – 4 x 2 day visits per year
 2. Paediatric Endocrinology - RCH Melbourne – 2 x 1 day visits per year
 3. Genetics clinics – Victorian Clinical Genetics Service – 4 x 1 day visits per year
 4. Paediatric Cystic Fibrosis and respiratory clinic - RCH Melbourne - 2 x 1.5 day visits per year
 5. Paediatric Rehabilitation – RCH Melbourne – monthly clinic (North West patients are seen in this clinic, and NWRH allied health staff attend this clinic)
 6. Paediatric Sleep clinic – Sydney Children’s – 4 x 1 day visits per year
- Two Paediatricians provide cover for the Sexual Assault Service.
 - A single Paediatric Clinic Nurse Coordinator provides support for the chronic outpatient care of children with complex therapies.

Current Staffing Profile:

- Paediatric services in the north are overstretched. There is a lack of VMO support in providing on-call and community cover.
 - The current Consultant roster is 1 in 4 for acute care. When annual/conference/sick/sabbatical and long service leave is considered easily becomes a 1 in 3. This is significantly less than regional centres on the mainland. Eg. Orange, NSW with a much smaller population than Launceston has 5 FTE Consultant Paediatricians and has a lower Paediatric and Neonatal role delineation. Bendigo, VIC has a similar population to Launceston and has 6 FTE Consultant Paediatricians.
- Outpatient services are similarly stretched with a waiting list stretching greater than 4 months for appointments.

North West

- The North West Regional Hospital paediatric medical service currently performs at a level 3.
- It exceeds some criteria for a level 3 service, but will fall short of a level 4 service due to the support requirement for a level 5 HDU/ICU and level 5 anaesthetics

Services:

- The THO - North West is home to the Rural Clinical School of UTAS, providing training and practical placement for medical, nursing and allied health students. Inpatient Services:
- There are 16 inpatient paediatric beds or cots at the NWRH and a short stay unit at the MCH Emergency Department capable of caring for paediatric patients for up to 24 hours.
- For Neonatal inpatient beds please see the WACS CAG - Neonatology response.
- The paediatricians also support the North West Private Hospital and MCH birthing units.

Outpatients

- On average there are 100 outpatient appointments offered each week across both NWRH and MCH campuses.
- 22 outreach clinics a year are funded by TAZREACH- and are conducted by a Paediatrician and Paediatric Nurse to Queenstown, Rosebery, King Island and the Circular Head Aboriginal Community.
- Video conferencing clinics are conducted from the NWRH to King Island. Some video conferencing clinics are received for outpatient appointments by the Royal Children's hospital Melbourne to NWRH.

Clinics run by local staff:

- The Paediatricians are supported by a clinical nurse in the paediatric outpatient department who offers nurse-led paediatric asthma and allergy outpatient clinics outreach to MCH.
- The NWRH and the MCH have a multidisciplinary paediatric diabetic outpatient clinic and inpatient support service.

Outreach Clinics provided from external providers:

- Paediatric Neurology RHH- 2015 dates confirmed for 5 visits to Burnie

Clinics provided by visiting interstate specialists:

- Paediatric Cardiology RCH- Melbourne 4 per year (across both campuses)
- Paediatric Endocrinology RCH- Melbourne 2 times per year to Burnie
- Paediatric Cystic Fibrosis + Respiratory – RCH – Melbourne 2 visits per year to Burnie

Current Staffing Profile:

- The North West is serviced 5.0 FTE specialists, 3.0 FTE registrars and 2.0 FTE RMO (across both Mersey Community Hospital and North West Regional Hospital) who provide 24 hour on-call service to both campuses.

Service Description – Levels 1 to 6

The CAG has reviewed the service descriptions for Levels 1-6 and considers the descriptions to be appropriate with some minor modifications as noted in the attachment

- It should be noted that there is no Level 6 unit in Tasmania.

• Role delineation for Paediatric Medicine- Recommendations changes:

Level 3 – Add formal linkages with higher level services

Level 4 – Add formal linkages with Level 5 and 6 services

Service Requirements – Levels 1 to 6

- The service requirements specified for Levels 1 -6 have been revised. Revisions to include the following additions:

- Role delineation for Paediatric Medicine - Recommendations changes:**

Level 1 - Access to more specialised paediatric care at a higher level service

Level 3 - Designated paediatric ward/area where children and adolescents are physically separated from adult patients; Isolation capacity in separate rooms; Access to appropriate Level 6 sub-specialty outreach services allowing for CPD for staff;

Level 4 - Access to educational program within hospital; Provides child protection assessments and referral as necessary

Level 5: Provides 24 hour Child Protection Services with consultant paediatrician and multidisciplinary team; Access to designated adolescent unit so adolescents and small children are cared for in separate spaces; on site school facility

Workforce Requirements – Levels 1 to 6

The service requirements specified for Levels 1 -6 have been revised. Revisions to include the following additions/deletions:

- Role delineation for Paediatric Medicine- Recommendations changes:**

Level 2 - RNs with skills and experience in caring for paediatric patients

Level 3 - Complex and chronic condition coordinator, access to inpatient and outpatient allied health including pharmacy, physiotherapy, occupational therapy, dietetics, speech therapy, social work and mental health

Level 3 - Delete On site Specialist Nurse Director for Paediatricians and replace with Nurse Unit Manager: include Teachers and Diversional therapy staff (for paediatric and adolescent patients)

Support Service Requirements – Levels 1 to 6

The service requirements specified for Levels 1 -6 are appropriate for acute inpatient services. Please note that Paediatric Services require the support of many services within the community that do not align with this role delineation framework.

These are listed in the Gaps, Risks and Opportunities section commencing on Pages 8-12

- Radiology staffing at the LGH is currently at a critical, unsustainable level.
- Allied health services including pharmacy, physiotherapy, occupational therapy, social work and speech therapy are inadequate at all sites.
- Pharmacy services need to be consistent with the service level for paediatric medicine at each hospital site.

Gaps, Risks and Opportunities

The Tasmanian population is more socio-economically disadvantaged and subsequently has a poorer health status. Tasmania has a high number of children in out of home care, high numbers of children not engaged in education, high rates of teenage pregnancy, significant numbers engaged in the youth justice system, and high numbers of young people presenting with suicidal ideation and completing suicide.

Paediatric workforce

Gaps:

Launceston and NW have a paucity of paediatricians, especially outside the hospital settings.

Risks:

- There will be ongoing and increased demand for General Paediatric services into the future
- Regions with fewer paediatricians providing outpatient services in the community face higher outpatient department referrals.
- Review in the community shifts costs to a federal model (Medicare) and may be cost effective for the state health department.
- The lower capacity of Tasmanian patients to pay out of pocket expenses must be considered.

Opportunities:

- Recruitment of paediatricians to these regions may need to be facilitated by the provision of VMO contracts or work in public clinics. Ongoing funding and support will be necessary.
- It has historically been difficult to recruit to the NW due to issues with workload, on-call, and location (see also Neonatal Services submission).
- Linkages between community based paediatricians and hospital services facilitates smoother transition of patients from community to inpatient settings where required.

Outpatient Services

Visiting Sub-specialists

Gaps:

- Visiting specialists have been organised region by region with overlap of some specialties and others not covered ie:
 - Paediatric Gastroenterology services
 - Paediatric allergy and immunology – especially food challenges
 - Paediatric Nephrology Services
 - Paediatric chronic conditions – for proactive management and coordination of care and rehabilitation
- The Tasmanian Patient Travel Assistance Scheme (PTAS) operates at great cost as children travelling interstate are accompanied by parent(s).

Risks:

- Cost to state, inconvenience to families, inequality of access.

Opportunities:

- Assess PTAS data to organise visiting specialists in disciplines where much money is spent sending children interstate (N.B. not all visits will be avoidable).
- Better use of telehealth may save some visits but this depends on the availability of the particular sub-specialist - many are unable to accept further patients.
- The CAG suggests promotion of the model of care currently provided to the Paediatric Cystic Fibrosis Service, where local multidisciplinary teams are supported by larger more experienced tertiary academic services at the Royal Children's Hospital Melbourne.

Local Clinics

Gap:

- Evidence suggests that people with chronic conditions should be reviewed by health carers more frequently to support self- management and compliance with treatment regimens.
- Ensuring access services in an area close to where we live is important for people with chronic conditions.
- Few nurse coordinators state-wide.

Risks:

- Efficient specialist RNs can deal with many presentations and referrals. Coordination of clinic visits and family requests may be performed more efficiently. This would be cheaper than medical specialists.
- These nurses cannot work completely independently unless they are a nurse practitioner, but would be very useful within a team.

Opportunities:

- Nurse coordinators and nurse run clinics may be an efficient use of hospital resources.
 - Support the upskilling of nurse practitioners.
 - Create multidisciplinary clinics that identify and manage chronic long term conditions
 - To assist in determining which services to focus on to expand the role of primary and community care, the CAG recommends an investigation of the services currently provided in the community. This would include identify how they are funded (Federal, State, Council, Community or Not for Profit).

Allied Health

Gaps:

- Hospitals in all regions suffer from a lack of allied health staff.
- Physiotherapists, occupational therapists, speech pathologists, social workers and psychologists are extremely important in paediatric care, especially in the outpatient setting.
- Community based allied health services in public are overstretched and can only provide limited service.
- Private allied health care is expensive, even with the few Medicare rebates available and is out of reach for many families.
- Robust community based services relieve pressure on hospital services by decreasing referrals to outpatients, providing timely and often more effective interventions and allowing earlier discharge of patients.

Risks:

- Behavioural problems, mental health problems, chronic conditions and developmental issues comprise a large proportion of paediatric referrals and consultations.
- With behaviour and mental health problems, evidence clearly shows that intervention in the early years to support parents in acquiring skills in child management is more effective for patient outcome and cost than interventions in later childhood or adolescence when problems have fully developed. (Please see recent coroner's report into youth suicide).
- In developmental medicine, children with developmental disability have better outcomes with effective early intervention to maximise their skills and independence.
- Lack of services for families with high needs children causes more severe problems in the future.

Opportunities:

- Recent perinatal mental health initiatives should be available across the state and funded.
- The current child health and parenting nurse network provides a basic network which could be strengthened to provide a better parenting support service.
- Early intervention programs currently in place such as ECIS and St Giles should be expanded.
- Hospital allied health programs should be enhanced and strengthened.

Adolescent Unit

Gap:

- Tasmania has no dedicated adolescent beds.

Risks:

- It is developmentally inappropriate for adolescents to be treated with infants or with old people.
- Adolescents with severe mental illness, at risk to others or themselves; are currently housed within adult mental health units which place them at further risk of harm and is a suboptimal environment for recovery.
- In RHH the paediatric nursing staff, makes tremendous efforts to keep unwell adolescents with psychiatric illness on the paediatric ward.

Opportunities:

- A dedicated adolescent unit with 'swing' beds (that can be converted to secure mental health beds) would provide unwell Tasmanian adolescents with a safe place to be treated and recover.

Drug and alcohol

Gap:

- Tasmania has no drug and alcohol rehabilitation beds for people under 18.

Risk:

- Addiction problems do not begin at 18.
- Adolescents as young as 14 present to Tasmanian hospitals with drug and alcohol issues.

Opportunity:

- Early treatment of drug and alcohol problems minimises life-long morbidity and decreases mortality

RHH Inpatient facilityGap:

- Small unit with too few beds, no adolescent unit.
- Poor school services (half time, primary based).
- No day hospital model to allow early discharge and day stays for longer term patients (rehabilitation and mental health)

Risks:

- Blockage of surgical lists when the ward is full with long-term or infectious patients.
- Loss of educational opportunity for long-term patients who are not provided with adequate educational support.
- Patients are kept in hospital longer due to inability to discharge for day hospital type admissions.

Opportunity:

- Instituting a day hospital model would free more beds and decrease wait times thus improving throughput and funding opportunities.
- Better educating our 'at risk' patients would come at a relatively low cost (education department high school teacher) with excellent long-term benefits.

Community PaediatricsGaps:

- The current specialist community paediatrician is based in the south and cannot provide clinical service in the N and NW.
- There is no accessible public mental health or psychological service for children who have suffered developmental trauma (e.g. children who have been severely neglected or emotionally abused).
- Tasmania has the highest proportion of children in out of home (state) care of all the states in Australia.

Risks:

- Abused and at risk children in the NW are not receiving the same care as those in other regions.
- Paediatricians in the North carry a larger relative burden of child protection work than those in the south.
- Children in 'out of home care' cannot access the services they need for better emotional development.
- Children with abnormal behaviour secondary to their previous experiences have more difficulties in education and relationships, often failing multiple foster care placements and requiring group home settings at great cost.
- They frequently disengage with school and fail to achieve enough education to be employable.
- They are at high risk of further trauma and drug and alcohol abuse.

Opportunities:

- one community paediatrician in each region would improve clinical practice and outcomes for abused and at risk children.
- A publicly funded psychological service for children who have suffered from developmental trauma and their families would improve outcomes for those children, decrease the need for therapeutic group homes, and decrease educational failure.

Rehabilitation

Gaps:

- Tasmania has large numbers of children with disabilities such as cerebral palsy but has been unable to attract a rehabilitation paediatrician to fill the state-wide position.
- Interstate services cannot accept the volume of patients from Tasmania requiring treatment.

Risks:

- That Tasmanian children with disabilities will fail to access treatments, such as botox to improve mobility, or receive referral for complex surgery in a timely fashion leading to increased disability and loss of opportunity.
- Sending children interstate for treatment is costly and disruptive.

Opportunities:

- Training of a local candidate to obtain the subspecialty qualification is underway. Ongoing support of the rehabilitation service will be required to ensure this service continues.

RECOMMENDATIONS

Recommendation 1:

Alteration of the TRDF as suggested.

Recommendation 2:

Increase the paediatric workforce in the North and North-West to ensure sustainability of services and the possibility of outreach services.

Recommendation 3:

Appoint a community paediatrician in the North and North –West.

Recommendation 4:

Continue strong links with Level 6 services interstate, including the use of strategic visiting specialists to strengthen local multidisciplinary treatment teams. Videoconferencing should increase where appropriate.

Recommendation 5:

Continue to send Tasmanian children requiring subspecialist services to Level 6 centres for treatment when subspecialists are not available in Tasmania as local or visiting specialists.

Recommendation 6:

Promote the role of RNs as coordinators of complex paediatric outpatient care and investigate a greater role for nurses within outpatient clinics.

Recommendation 7:

Build good communication, education and referral links between community-based services working with children and families and the hospital teams.

Recommendation 8:

Strengthen allied health services both within the hospital and in the community, including in the areas of early intervention, early behavioural and mental health support and parenting support.

Recommendation 9:

Improve the CAMH Services in the North and Northwest.

Recommendation 10:

Establish an Adolescent Unit in Hobart with the capacity to manage (amongst other conditions) complex psychiatric patients, and a day hospital facility to enhance the discharge process and decrease admission length.

Recommendation 11:

Improve drug and alcohol services for young people including the establishment of inpatient beds and improved communication with hospital teams.

Recommendation 12:

Provide ongoing support for the improvement of the paediatric rehabilitation service, ensuring close links with paediatric medical services and a state-wide service.

Recommendation 13:

Ensure that all children in hospital have access to appropriate educational opportunities by appointment of teachers and establishment of school rooms.