

In responding to the Green Paper, we support the government's approach to deliver health services to Tasmania on a statewide basis. The Tasmanian State-wide Surgical Services Committee (TSSSC) offer the following response to the Green Paper, in an effort to ensure that we take advantage of this opportunity to have a safe, high quality and sustainable health service going into the future.

Delivering Safe and Sustainable Clinical Services

The TSSSC agrees with the position that the current health system is unsustainable, however some of the assertions regarding the quality of the services that are made in the Green Paper are questionable. We need to ensure that services are improved and sustainable by working together to develop a white paper which will document a detailed plan that delivers quality, safe and sustainable health services to all Tasmanians.

We have elected to provide a response addressing all issues from the Green Paper rather than just addressing the questions posed by the Green Paper. We are of the opinion that this will provide a more appropriate response that fully addresses the issues as there are some fundamental assumptions on which the Green Paper is based that are either unsound or impractical. Therefore in the interests of ensuring that the White Paper is deliverable and sustainable we are of the opinion that it is essential that these issues be addressed at this point in time.

The Tasmanian Government has given a commitment to rebuilding Tasmania's health system in a manner which prioritises essential health services. The TSSSC agrees with service prioritization. We also stress that there are two additional equally important objectives: 1. Ensuring patients are kept at the focus of all decisions, and 2. Outcomes must be measurably improved. We consider that improved patient outcomes are not always achieved by concentrating services at one site and duplication of services does not necessarily result in a poor quality service nor lead to an increase in health costs. In certain circumstances services can be delivered more economically by duplication which provides timely access to a service without all the associated additional costs involved with transfer. Local access does not always mean poorer clinical outcomes and the availability of many surgical services at every large hospital does not necessarily mean that patients wait much longer than clinically recommended. However in contrast some services should not be duplicated as this makes them less efficient and may compromise quality. It is a matter for individual consideration in all of the circumstances.

It is disappointing that some of the assertions in the Green Paper are lacking relevant citations and reference to the supporting data or evidence. These assertions lack the appropriate citation and evidence which would then enable the underlying assumptions to be reviewed informatively.

We remain unconvinced how the establishment of a single Tasmanian Health Service (THS) will improve clinical consistency, as the Clinicians must always be allowed authority to make clinical decisions. The Surgical Patient Journey, particularly for elective surgery, is one continuum which must be safe efficient and optimised. Any movement of

patients between sites will require robust systems processes to be agreed including appropriate clinical handover and clinical collaboration focused on shared delivery of care.

It is important to recognise the potential impacts of major change to the Tasmanian health service staff however the impetus behind the proposal stems from a patient centred care approach and a need to implement a change in processes to improve patient access to care

The TSSSC fully supports strengthening intrastate and interstate clinical partnerships as proposed in the Green Paper. Evidence based data should support clinical decisions that drive interstate transfer. Relevant and robust evidence based data should support all decision making. Where interstate transfer is deemed most suitable for specified patients, the decision taken should reflect the appropriate level of clinical engagement in the process. In strengthening interstate these relationships there is the opportunity to further our learning, teaching and research through collaboration between institutions

Greater collaboration with the community, patients, funders, the hospitals, DHHS and other stakeholders is an essential inclusion in the Green Paper and supported by TSSSC..

Recommendation 1

The TSSSC be the clinical advisory body defining role delineation framework for General Surgery and that the TSSSC membership reflects Statewide representation

Delivering Safe and Sustainable Clinical Services Issues

1. Volume Safety Equation

The Green Paper speaks very strongly in respect of a volume/safety or volume/quality equation. It has been repeatedly shown that higher procedure volumes, by hospital and by clinician, are associated with better outcomes for certain areas of highly complex surgery. However, the implications of this have not been clearly established for all procedures. There are many other factors that play into the equation and it is unfortunately not as simple as just looking at volumes of surgery performed. This is one of the reasons that while NSW has gone down the track of establishing high volume centres for some procedures such as pancreatectomy and oesophagectomy it has not done so for most other procedures. In NSW this process has been undertaken with significant involvement of the Royal Australasian College of Surgeons (RACS). In contrast Victoria has actively made the decision not to go down this path at all.

Recommendation 2

All hospitals within the State , at all levels participate in a Surgical Services data set to accurately capture all activity, performance and outcomes at state level to guide further refinement of the state surgical service at strategic, operational and clinical levels

The TSSSC supports the role-delineation framework with the aim to concentrate services at the most appropriate sites. Such role delineation will be defined by clinical support capability and patient needs.

Factors that require consideration by the Clinical Advisory Group (CAG), the Tasmanian Health Service (or currently the THOs) and the DHHS in assessing role delineation include:

- The volume of procedures undertaken in both private and public hospitals. Volumes in private may be higher compared with the public sector and in some areas many of the same support staff will be involved in both sectors. When aggregated the volume may more than satisfy potential concerns regarding quality and safety of the service delivered.
- The training and level of experience of the surgeon/anaesthetist/nursing (instrument/anaesthetic and recovery) are also important. For example a surgeon who is trained as a generalist surgeon who has many years of experience may well be capable of producing superior results to those results produced by a less experienced surgeon in a unit with greater volumes.
- A unit with greater volumes may well have lesser numbers of procedures performed by individual surgeons but they have more surgeons in comparison to a smaller unit. For example there are surgeons performing breast cancer procedures in Tasmania who would be considered very high volume surgeons by mainland standards although the total volume of cases through the unit is much smaller than many mainland units. What is important in these circumstances is the access to multidisciplinary teams and accessibility of support services. Provided the appropriate supports are in place then volume alone is an insufficient indicator.
- The Green Paper asserts all 4 public hospitals in Tasmanian function using a subspecialist model of care. This is not accurate for all sites. Whilst the Royal Hobart Hospital does predominantly run a subspecialist model of care, Launceston General Hospital, Mersey Community Hospital and North West Regional Hospital run generalist models of care, i.e. the surgeons at these hospitals are general surgeons with interest areas such as breast or colorectal surgery, general orthopaedic surgeons with an interest area such as spinal surgery, or general urologists with an interest area such as stone disease. The role delineation profiles outlined in the Green Paper allow interpretation of these generalist/specialist roles. Further discussion within the Clinical Advisory Group is needed in relation to volume/quality in respect of individual procedures.
- If surgery in a particular area is concentrated in certain units on the basis of a perceived volume/quality relationship it is inevitable that those generalist surgeons will become deskilled in that area. This is in conflict with the position put reasonably strongly in the green paper that Clinicians should practice to the limits of their scope of practice and should be supported to do so. Specific scenarios of

critical surgical emergencies require development of clear guidelines and agreed clinical pathways acknowledging the contribution made by generalists with a subspecialty interest in time limited circumstances.

- Upper Gastro-Intestinal and Hepato-Biliary surgery such as pancreatectomy and oesophagectomy is specifically considered by the Green Paper and a significant loss of patients to the mainland to both the public and private sector is identified. This occurs because the hospitals in Tasmania do not currently have the resources to deal with the number of patients requiring these services; the service exists but is insufficiently resourced to provide for the number of patients requiring surgery for what are time critical conditions and those patients are therefore referred to hospitals in Victoria. Appropriate resourcing to undertake these cases in Tasmania needs to be delineated.

Recommendation 3

The TSSSC supports the role delineation framework for Tasmania in relation to General Surgical services.

2. Clinical Advisory Groups

The opportunity for clinical input via Clinical Advisory Groups (CAGs) into the way in which health services are delivered in Tasmania is supported by TSSSC. The governance structure of CAGs requires clarification. Each CAG needs appropriate clinical statewide representation to determine priorities between competing clinical interests.

Along with effective representation from all stakeholders it is essential that the governance structure facilitates clinical input into the decision making for health services, otherwise CAGs risk creating unrealistic expectations amongst clinicians.

The Surgical CAG will work across the whole of the Tasmanian health care system to inform and lead improvement in service delivery. It is intended that CAGs will be a way of linking health service providers (and consumers) that will build on and enhance existing formal and informal networks.

The Surgical CAGs will consider the allocation and distribution of services across the state; regional cooperation and coordination; quality and safety; professional and strategic clinical issues; specialist workforce; education and training; and research.

Underpinned by clinical leadership, the Surgical CAG will provide clinical expertise and an opportunity for all health professionals to work collaboratively, to establish shared goals and formulate achievable work plans.

Recommendation 4

Tasmanian State-wide Surgical Services Committee (TSSSC) with both advisory and operational roles will function as the Surgery, Anaesthesia and Acute Pain CAG.

This group includes in its membership clinicians, senior access nurses and the THO CEOs, with the addition of anaesthesia and acute pain representation.

3. Statewide Waiting Lists

It is clear that the Minister for Health is committed to the delivery of statewide waiting lists to ensure equality of access to services across the state. How this will be accomplished is not clear. The discussion paper on elective surgery remains silent on this issue.

Equity of access to public services is a fundamental principle supported by the TSSSC. It is important as the surgical CAG that the TSSSC provide input into all decision making around management of waiting lists and delivery of surgical services, particularly given the interdependency of many surgical, anaesthetic and acute pain disciplines.

There are a number of aspects of concern in how this aspect is handled. Firstly it is clearly appropriate that there needs to be equity of access and it is essential that we deliver this. It is the manner in which we do this that will determine whether we succeed in this aim or not.

TSSSC acknowledges that our state hospitals may have previously been observed to function as single or regional entities without a coordinated state wide focus on the delivery of equitable access to elective surgical procedures except on a case by case basis, in many instances.

We share the concerns raised in other forums about the extent to which this has led to a perception of mis-match of workload and resources (such as capacity, infrastructure, funding and workforce).

Issues include

- Not all surgeons will operate in the same circumstances. Individual clinical decision making results in differing thresholds for operating amongst the surgeons even within one craft group. In addition, the procedure that is preferred by one surgeon for a clinical condition may not be effective in the hands of another surgeon. This does not result in poor outcomes for the patient, in fact it can mean better results. This should be directed by Surgical CAG advice.
- Currently at the LGH 60% of the waiting list is contributed from private rooms (as a single example). It is the position of the Royal Australasian College of Surgeons (RACS) that the surgeon providing the procedure should also be responsible for the preoperative assessment, the consent and the postoperative care. Centralised waiting lists would potentially result in double handling those patients through outpatients in an already overcrowded and overburdened system to ensure the clinical review process is in place by the surgeon who will perform the procedure.

- One of the reasons that patients do not commence medico-legal action even when things go wrong is because of the pre-existing relationship with the doctor concerned. In the case of a centralised waiting list the surgeon patient relationship is lost and the surgeon becomes little more than a name on a bed card at the head of the bed.
- Patients travelling to another region for a procedure return to their place of residence post-operatively. Complications may occur after the patient has returned home. There is a clinical risk with such a scenario because the emergency department and surgeon who are confronted with the complications may lack sufficient clinical information. In complicated circumstances even the most comprehensive note will not convey all of the information that would be available to the surgeon who performed the procedure. The options are either to transfer the patient back to the site of surgery at significant cost in terms of money, time and inconvenience, or deal with the complication as presented. There are many lessons to be learned from the English NHS experience with contracting surgical activity to Spain. In those circumstances while the bureaucracy found this to be a successful experience the story was very different for many patients and clinicians.
- The costs of shifting a patient from their place of residence also need to be considered. These include not only the monetary cost of the travel but also a raft of costs resulting from removal of the patient from their support network, when they are undergoing a traumatic experience because although surgery is for us an everyday experience it is very different for the patient and this can significantly impact a patients' recovery.
- Surgery is a complicated experience. As a surgeon it is difficult to manage patient expectations on many occasions. There is a risk that we may create a system that increases the chances of raising patient expectations to a level that is beyond that which can be delivered.

It is possible to consider whether a pooled central waiting list may work for a limited range of procedures but again a lot of the same issues will arise. Alternatively patients could be approached to see whether they would be interested in receiving care in an alternate location. Unfortunately this approach would also not alleviate many of the risks discussed above. This has previously been undertaken in the state with limited success.

Perhaps a way of delivering Statewide Waiting Lists is to publish to the public, the Primary Health Care sector and in particular the General Practitioners (who are responsible for referral of patients to surgeons) all of the details about different surgeons waiting lists. This and some education around referral patterns and expectations for the GP's may be a way to balance the number of patients per site. This could be done on a regular basis or a live IT portal could be created such that waiting list information could be visualized in a totally transparent manner in real time. This would enable General Practitioners and patients to make informed decision around to whom and to where they were referred.

In addition, increased mobility of the surgical workforce should be considered. Surgeons should be accredited at all hospitals and be encouraged to undertake surgical lists at alternate hospitals in combination with local surgeons such that more specialised care may be delivered close to home where appropriate. Alternately patients may be transferred to a centre with greater surgical expertise, accompanied by their local surgeon who could then undertake their post-operative care once the patient was significantly recovered and able to be transferred to their local hospital.

4. Agreed Data Definitions

An area touched on in several aspects of the Green Paper but needing further development, is the establishment of agreed data definitions and dates for drawing of that data. Hand in hand with this is an agreement around governance of data. Argument over whose data is correct has been a constant feature of the Tasmanian Health System for a very long time.

Recommendation 5

Surgery CAG needs to identify an agreed data set and support appropriate Governance model.

5. Performance and Recognising Current Success

The Green Paper describes the Tasmanian Health System as underperforming and that there is clearly room for improvement. There are areas in which the system is underperforming and where improvement is required. Alternatively, it is also clear to those of us who work at the coalface that there are areas where the delivery of health care is of a high standard. It is important that in reforming the system those aspects that are working should be highlighted and built upon in parallel with redesigning the areas of poor performance. This would go a long way to engage clinicians in the process which is vital to the success of the reforms.

There is the risk that in an attempt to wipe the slate clean for the Tasmanian Health System we create an enormous void that it is impossible to fill in the time available to us and therefore we doom this process which has much to recommend, to failure. We should reform those areas that require it, retain those areas which are functional and do so in a rational agreed statewide fashion that ensures that things don't fall over as changes are instituted because there has been an inability to put into place all of the machinery to ensure that the changes succeed.

6. Funding and the Senate Select Committee on Health

It is acknowledged that the Tasmanian Government is in a difficult financial position as is clearly stated in the paper on sustainability supporting the Green Paper. It is also worth noting that the Senate Select Committee on Health challenges the assertion made in the Green Paper that we just have to do more with less in its first interim report. In this report the Committee suggests in contradiction to the Green Paper that in fact Health is

underfunded when worldwide comparisons are made and challenges the Federal Government to change its stance on pulling \$50 billion out of healthcare funding over the next 10 years.

It is correct that we can always do things better and more efficiently and to deny this is erroneous but by the same token it is incorrect to say that we can deliver the best health care system by 2025 without adequate, appropriate and additional funding. Without an acknowledgement that additional funding will be provided health care rationing within the state will be required as efficiency and rationalisation of services gains will be insufficient to address the shortfall. If we are truly planning for the future in an open transparent and practical way then it is essential that we address this issue now and not lose this opportunity through political rhetoric.

7. Integration of State and Commonwealth Services

As discussed in the Green Paper we are subject to the dysfunctionality thrust upon us by the divisions between a Federal and State Health System. This does lead to a duplication of services which can be inefficient as information from the private Commonwealth funded system is not always available in the State funded public sector and vice versa. It can only be hoped that through efforts at collaboration and with the development of further information technology that these issues can be addressed.

There is a hidden silver lining to this cloud that should not be underestimated. In particular this is the significant contribution that the private sector makes to the work up of public patients who then go onto the waiting list for their surgery. For example 60% of the waiting list at the LGH go down this pathway and it is at no cost to the State but rather funded by a combination of the patient and the Commonwealth Government.

8. Public and Private Services

In Tasmania there is a codependence between the private and public sectors. The private sector depends on the public sector to supply the high-end complicated services and the public sector depends on the private sector to undertake a volume of work that the public sector could not accommodate both from a volume and fiscal point of view.

Workforce

It is also important to recognise particularly in surgery that the workforce for the public sector are in many cases the same workforce as the private sector. There are a number of aspects to the private sector which combined with access to greater volumes of work facilitates recruitment of adequate numbers of specialists. In surgery it is important to appreciate that staff specialist models of care do not always work as it may well not be possible to occupy a full time staff specialist for an adequate number of hours per week unless less specialists are employed thus reducing an ability to staff an on call roster.

In assessing volume it is essential to consider throughput in the private sector as well as that in the public hospital given volumes will be significantly higher in private for a number of procedures potentially making services viable that would not be viable on a public volume alone.

The TSSSC is encouraged that the Green Paper seeks to develop further synergies between the public and private sectors although it is important that capacity within the public sector is utilised prior to contracting out services to the private sector as training opportunities are in general better able to be utilised in the public sector as evidenced by the various training programs run by the learned colleges throughout Australia.

It is essential that we maximise our training opportunities as training registrars are often the source of our consultant staff in the future and to say that for most surgical specialties we are in a highly competitive market understates the difficulties in recruiting significantly.

9. Generalist Model of Care

The Green Paper asserts that all 4 public hospitals in Tasmanian function based on a subspecialist model of care, this is not true. From a surgical perspective, while the Royal Hobart Hospital does predominantly run a subspecialist model of care, the Launceston General Hospital, the Mersey Community Hospital and the North West Regional Hospital all run generalist models of care.

The TSSSC is firmly of the opinion that further development of generalist models of care through establishment of rural and regional training hubs and growth of supports around extended scope of practice to support the development of generalist surgeons should occur. The surgical directors at each hospital should scrutinize their workforce to ensure that excessively narrow sub-specialization is not allowed to creep in, leading to deskilling, a situation which turns from general surgeons with a specialty interest, into specialty surgeons with a progressive shedding of their general scope of practice. This could be facilitated by working with the RACS in instituting the regional training hub currently in the planning phase for Tasmania.

The support for a generalist model of care and for clinicians practicing and being supported to practice to the limits of their scope of practice that is presented in the Green Paper is welcomed and strongly supported.

10. Trauma Role Delineation

The Trauma Clinical Advisory Group (Trauma-CAG) is supported as the group for advice on statewide trauma issues. The Trauma CAG should work closely with the TSSSC, the RACS and particularly the National Trauma Committee of the RACS to ensure that robust role delineation and clinical collaboration is facilitated in the interests of statewide trauma management.

The elective surgery role delineation profile should harmonise with the requirements to provide a trauma services. Emergency surgery is increasing state-wide at approximately 3% per annum. This results in a negative impact on elective surgery capability.

From the role delineation framework the North West Regional Hospital (NWRH) will fall into the category of a Level 4 Trauma Service, the Launceston General Hospital (LGH) a Level 5 Service and the Royal Hobart Hospital (RHH) a level 6 service.

Appropriate models of care for this role delineation requires development as for example it is inappropriate to routinely transfer all major trauma cases from the NWRH within a 24 hour time period and from LGH within a 72 hour time period, transfers should be on clinical grounds. This is for two reasons, the patient may not benefit from the transfer if their definitive management has been completed and they are recovering and they may actually be harmed by being bounced around in the transfer if for example they have solid organ injuries that are being treated conservatively. It should also be considered that such an approach would result in a significant volume of patients being transferred to the RHH which already has capacity issues and is about to embark on a major capital works project that will further impact on capacity.

A high priority is establishing better collaboration between the 4 major hospitals such that those patients who will benefit from transfer are more easily able to be transferred and those who will either not benefit or potentially be harmed by the transfer are managed locally.

Guidelines and pathways for referral of patients to the appropriate trauma service needs further development through the Trauma CAG in collaboration with the TSSSC, the RACS and particularly the National Trauma Committee of the RACS. A 30-minute limit around the LGH is inappropriate as it is inappropriate to transfer a trauma from Georgetown or the North East that may well be managed at the LGH given that the transfer times are significant. This is especially the case where rotary aircraft are limited in their operation for significant times of the year due to weather limitations and there is only the one fixed wing aircraft. It would be advisable to again improve collaboration to ensure the right patient is in the right place at the right time. Unnecessary transfers and unnecessary duration of transfer will adversely impact on patient outcomes as well as become unnecessarily expensive. Urgency of treatment is behind the concept of the Golden Hour in terms of trauma treatment as taught in the Emergency Management of Severe Trauma (EMST) Course by the RACS.

State-wide trauma services must be managed in addition to the state-wide elective surgery development role delineation and the two must not compete for services.

Recommendation 7

The TSSSC recommends that improved management and separation of service streams to avoid competition for resources between emergency and elective streams in line with the RACS position paper on the Separation of Emergency and Elective Surgery

11. Subspecialist Role Delineation.

The development of role delineation and the Role Delineation Framework is wholeheartedly supported. In the areas of subspecialist role delineation a detailed analysis is required where there is representation from all stakeholders and jurisdictions to ensure a functional state-wide result is achieved. There is sufficient scope within the TSSSC to facilitate this by co-opting appropriate representatives as required and given there are significant co-dependencies between various surgical and anaesthetic groups this is the appropriate venue for this to occur.

Recommendation 8:

The TSSSC is the appropriate venue to facilitate surgical subspecialty role delineation

In general there are some principals which should have an overarching role. Placing the Director of the Statewide Service in the position of deciding upon the scope of practice of surgeons outside of the RHH is placing the Director in a position of a fundamental conflict of interest, particularly given that there is a limited pool of private work in some subspecialties. The scope of practice is appropriately determined by the relevant credentialing committee who may seek advice from an interstate subspecialty surgeon, as necessary.

Some consideration of Vascular surgery and paediatric surgery role delineations is given below as an example of unintended consequences should a unnecessarily rigid role delineation framework be adopted. It is the view of the TSSSC that there should be some flexibility within the role delineation framework that can be informed by the relevant aspects of the CAG such that care is delivered in the most patient centered manner possible. For this to occur, flexibility and clinical advice and engagement is essential.

Vascular Surgery

There is benefit in altering the Vascular Surgery Role Delineation Framework to better align to how services are currently delivered as this is of significant benefit to the patients.

Some additional reworking of the divisions between Level 4, 5 and 6 needs to be undertaken to reflect the availability of services that are essential in an emergency situation. This is because it is unreasonable to expect a generalist surgeon who has been deskilled by a restriction in his scope of practice to suddenly perform those procedures that he has not been performing recently in an emergency situation. This is particularly so where the LGH has a hybrid theatre available and many vascular emergencies are unable to be transferred in a manner that will allow for the pathology to be addressed in a timely fashion. These range from issues with bleeding to issues with ischaemia, where a part of the body has lost its blood supply. To restrict a scope of practice in this manner also goes against many of the principles expounded in the Green Paper around the development of

the generalist model of care and clinicians practicing the full extent of their scope of practice and being supported to do so.

It is noteworthy that there is currently an oversupply of vascular surgeons in Australia and hence a resistance by vascular surgeons to train generalists in vascular techniques. This is in contradistinction to almost all other surgical subspecialties. In many cases the more recently trained vascular surgeons have significantly less experience in many aspects of open vascular surgery than those less recently trained generalists who practice with a vascular interest.

A reworked version of the vascular role delineation is attached (attachment 1) that has been developed with input from senior interstate vascular surgeons

Paediatric Surgery

Similar issues arise with the Paediatric Surgery Role Delineation Framework, but in many ways they have already been able to be dealt with because of the collegiality and collaboration that exists between the surgeons both subspecialist and generalist. It would be advisable to address this in the Paediatric Surgery Role Delineation Framework so as to ensure that the documentation accurately reflects what is agreed and happens in practice.

12. Sustainability

It is clear that services that are single person dependent are not sustainable in the long term. It is agreed that where possible these services need to be redesigned. In some areas redesign can be achieved by promoting the generalist model of care that is discussed extensively in this document and in the Green Paper. In some areas single person dependency may be a necessary evil such that time-critical problems can be addressed at least in the short to medium term and better alternatives may be established in the long term.

13. Practicalities of Travel, Patient transfer and bed availability

The role delineation framework does not describe inter-hospital transport or pre hospital care.

The practicalities of travel must be considered. If services are going to be relocated then it is essential that the necessary mechanisms be in place before that relocation occurs. If this is not the case then patients will be compromised as they fall into the gaps. The current NEPTS transport system is very often unavailable and sites are being forced to utilise costly private non-urgent patient transport in order to move patients between facilities to facilitate effective and timely patient flow. The current emergency transfer retrieval system also requires full review given the delays in and length of the transfer times.

Inherent in any process that requires travel or transfers is the risk of that travel or transfer in and of itself. This is well established in retrieval medicine. This includes the delay in

treatment, perhaps less of an issue in the elective setting but definitely an issue in the emergency situation.

Consideration must be given to patients' families and how they will be accommodated in areas away from their home base. Patients' families are key to the patients' emotional wellbeing and support from family members is essential. Moving services to one centralised area will require logistical planning and funding to support family members in such situations.

It is essential that capacity be created at the receiving location. This will require significant consideration as there is little spare capacity in any of the major public hospitals and the RHH is about to enter a major capital works project that will further impact on capacity.

Again the practicalities of deskillling a generalist work force need to be considered as discussed above. This is particularly an issue in time critical situations.

Recommendation 8

A Tasmanian funding model developed using a mixture of *activity based funding* and *block funding* that recognises the state service delivery burden and that matches clinical services, performances and activity.

Recommendation 9

The role delineation framework does not describe *inter-hospital transport* or *pre hospital care*. These are critical components of the proposed sustainable state surgical system.

Ambulance Tasmania needs to be intimately involved and engaged in the generation of the White Paper and development and implementation of the RDF and operation and governance of the state surgical system.