Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

8 May 2015

One Health System
Department of Health and Human Services
GPO Box 125
Hobart TAS 7001

Dear Minister

Thank you for the opportunity to comment on the White Paper – Exposure Draft *Delivering Safe and sustainable Clinical Services.*

The Australian College of Rural and Remote Medicine (ACRRM) is once again pleased that many of the issues identified by ACRRM and suggested solutions have been given consideration in this White Paper.

ACRRM agrees that those matters identified in the consultations undertaken following the release of the Green Paper have particular relevance to patients and communities in the more rural and remote parts of Tasmania.

ACRRM also notes the strong sentiments expressed at recent public meetings by rural communities concerned at the perceived reduction and accessibility of some hospital services in more rural areas of the state, notably at the Mersey Community Hospital.

With this in mind, ACRRM believes there are a number of issues that require greater emphasis, clarification or a carefully considered proposal to ensure acceptance, support and ownership by patients, communities and the health professions.

1. eHealth services

ACRRM is pleased to see a number of references to the use of Advanced Technologies and Innovation for the sharing of information, accessing medical support, conducting outreach clinics, monitoring patient health, and teaching and learning.

ACRRM has considerable experience in the development and application of eHealth concepts including the development of standards endorsed by generalist and specialist practitioners and the relevant Colleges.

Within Tasmania, the Polar Medical Unit of the Australian Antarctic Division has pioneered and refined Telehealth services over vast distances. The DHHS could draw on these experiences to enhance services to the wider Tasmanian community.

ACRRM also notes that "simpler" technologies such as Telephone Triage services for patients, Rural Health facilities, Aged Care facilities and ambulance services to access advice and guidance after hours have been shown to reduce lower acuity presentations to hospital emergency departments as well as easing the onerous after hours load on rural GPs. These services deserve ongoing and enhanced support as part of delivering clinical services.

ACRRM is also working with GPs on the west coast of Tasmania to streamline implementation of the *MyHealthRecord* . ACRRM is keen to work with Tasmanian Government and the Primary Health Network to develop a submission for Tasmania to be selected as one of the sites for eHealth implementation as announced in the 2015 budget papers.

2. Primary care

A strong Primary Care system is one of the key messages identified in the consultations undertaken in developing the Green Paper. Unfortunately, the White Paper focuses largely on Acute Care within the hospital system.

ACRRM urges the DHHS to move forward and undertake more extensive consultation with GPs, the Primary Health Network and other health professionals working in this area.

The Physician Assistant concept should also be considered in the "innovative workforce roles".

3. Rural Health facilities (District Hospitals)

The White paper gives little mention to these facilities and the vital role they play in smaller communities. The Rural Generalist model is also highly applicable to these facilities and will help ensure that safe, sustainable medical services are provided within local communities. Unfortunately, inpatient services in most of these facilities have been allowed to run down to the point that they can provide little more than respite care.

The experience in other Australian states has shown that appropriately trained and supported generalist medical and nursing staff can safely provide a broad scope of practice across many disciplines including obstetrics, paediatrics, adult medicine, rehabilitation and palliative care.

4. Education and Training

It is pleasing that the White Paper identifies an opportunity to maximise local training pathways for local graduates.

The opportunity to develop the Mersey Community Hospital as a "Centre of Excellence" for Rural Generalist Training should not be ignored. (See further detail under Point 5 below).

At the same time, it should also be realised that the removal of complex surgical services from the North West coast will reduce training opportunities for medical practitioners-in-training on specialty pathways. This will have a flow on effect in the recruitment and retention of specialist medical, nursing and allied health practitioners, and consequently the range of services available to the local community. ACRRM disputes the implication that bigger centres with larger caseloads will always provide better and safer clinical services than smaller facilities.

Of great concern is the reduction in funding for universities by the Federal Government. The future of the UTAS Rural Clinical School and the "pipeline" of students on rural pathways into rural practice can only be sustainable with an adequately funded health system delivering a broad scope of services that matches the training needs of the students with the health needs of the community. ACRRM urges the Tasmanian Government to be part of the conversation with the Federal Government and the University of Tasmania to ensure relevant education and training continues to be available in Tasmania.

5. Mersey Community Hospital

This complex situation deserves special consideration to achieve a solution acceptable to the community.

To develop an institution the size of the Mersey Hospital as a Rural Generalist focused hospital would gain national attention and create a strong sense of pride and ownership by staff and the local community – provided the hospital continues to provide a broad scope of medical services; trains health professionals to deliver those services; provides a continuity of care across inpatient, outpatient and community services; and is fully integrated with Primary Care and more complex state-wide acute services.

ACRRM puts forward the following recommendations regarding the Mersey Community Hospital:

a. Emergency Medicine

ACRRM welcomes the proposal to introduce the "rural generalist" model for medical staffing the Mersey Emergency Department. Not only will this help reduce the enormous cost of employing "fly in fly out" locums with a very limited scope of practice, it will also provide practitioners more appropriately trained to manage the case-mix of patients presenting to this hospital (including stabilising more seriously unwell patients).

ACRRM cautions against limiting emergency services at Mersey Hospital to a "daytime only" service as this is potentially unsafe, will be unlikely to gain acceptance by the community, and onsite medical support is still required by those continuing inpatients in the hospital.
As it will take some time to fully develop the Rural Generalist model, ACRRM urges the DHHS to commence consultation with the relevant Colleges and other parties to progress this model.

b. Maternity services

The potential loss of maternity services from Mersey Hospital (or from North West Regional Hospital) will provoke much community concern. ACRRM proposes that a Rural Generalist/Midwife level of maternity services be continued at Mersey Hospital for those women meeting the criteria for low risk pregnancies. Women identified as requiring more complex medical care would need to be managed at a more specialised unit in Burnie or elsewhere. This model is well accepted in other parts of Australia and has demonstrated a high level of safety. It would of course meet the needs of the majority of pregnant women in the Mersey catchment area.

ACRRM urges the DHHS to commence consultation with relevant Colleges, the midwifery staff of the Mersey Hospital and other parties to progress this model.

c. Rehabilitation and Palliative Care services

As identified in the White Paper, a greater availability of these services in the North West is highly desirable. The White Paper proposes the establishment of nurse led subacute services at the Mersey Hospital supported by specialist practitioners from Northern and Southern regions.

ACRRM believes that the medical input for subacute services (particularly Rehabilitation and Palliative Care) lends itself to the Rural Generalist model and specialist input is only necessary for small numbers of more complex cases.

ACRRM recommends the Mersey Hospital be the principle centre for subacute services for the North West region with a Rural Generalist model (supported by specialist practitioners when necessary), fully integrated with dedicate Nursing, Allied Health and Primary Health services and providing outreach services to the North West Regional Hospital and Rural Health Centres.

d. Inpatient General Medical services

The White Paper recommends that General Medical services in the North West be consolidated at the NWRH.

ACRRM notes that the vast majority of General Medical inpatients across the country are older people with multiple chronic comorbidities, where an acute exacerbation has precipitated the presentation to hospital. The admission is often complicated by the patient's social circumstances relating to mobility, home support, and other activities of daily living. The medical needs are often relatively basic with the nursing and allied health requirements being the main determinants of suitability for discharge back to the community.

Once again, ACRRM maintains that such patients can very often be appropriately managed by a Rural Generalist medical model in conjunction with a multidisciplinary nursing and allied health team. Specialist medical input is only required for those patients with higher level complex illnesses.

ACRRM recommends that Mersey Hospital continues to admit General Medical patients under a Rural Generalist model of continuity of care with specialist input as required by NWRH and visiting outpatient services.

e. Surgical and anaesthetic services

ACRRM welcomes the proposal to expand and enhance the range of Day Surgery procedures at the Mersey Hospital.

While a component of this will be highly specialised surgery, the nature of Day Surgery means that the emphasis is on elective, low complexity, short duration procedures for patients without significant comorbidities. These cases do not always require specialist and sub specialist surgeons to perform the procedure. Endoscopy procedures are a good example of such cases.

ACRRM maintains the Rural Generalist model is also highly applicable to selected low risk, low complexity surgery. The anaesthetic services for such surgery also fits very appropriately

with the Rural Generalist model. Such models still exist in rural Australia and ensure that the local population has access to a broad range of services without the need for travel and the associated dislocation from family and community.

ACRRM trusts that these comments and recommendations contribute to the development of Safe and Sustainable Clinical Services in Tasmania. The College looks forward to having a continuing involvement in this process.

Yours sincerely

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Australian College of Rural and Remote Medicine