

## **Response to Tasmanian Department of Health and Human Services Green Paper: Delivery Safe and Sustainable Clinical Services**

In responding to the Green Paper, we welcome the government's approach to the development of a clear plan for the delivery of health services to Tasmania on a statewide basis. We are pleased to offer this response 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.

We agree that 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. In any event that is moot as the most important aspect is to ensure that services are improved and sustainable into the future by working together to develop a white paper 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 aim must always be to improve patient outcomes. Improved patient outcomes are not always achieved by concentrating services at one site. In some instances, duplication of services does not necessarily result in poor quality or lead to increase in 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 clinical decision-making MUST always remain a matter for the clinician and their patient. The Surgical Patient Journey, particularly for elective surgery, is one continuum. The pre and post operative follow up is as important to the patient and the quality of care provided as the surgical procedure itself. Thus the movement of patients between sites in some instances will require robust clinical handover systems and agreement by the clinicians to provide care in this way.

Once this change, and what could be seen as relatively radical reform is instituted, it is important that further change is incremental so that stability and certainly is allowed to occur. Otherwise there is a significant risk of change fatigue and the risk of clinicians not engaging in the process.

It is essential that we strengthen our interstate partnerships as proposed in the Green Paper and we need to move away from the concept that all services must be provided on the island. The current opposition to interstate transfer where appropriate, must be overcome. In strengthening these relationships there is the opportunity to further our learning, teaching and research through collaboration with larger institutions on the mainland.

Greater collaboration with the community, patients, stakeholders and greater cooperation with the DHHS and between the major public hospitals is essential and its inclusion in the Green Paper is much welcomed.

#### ISSUES:

##### **1. Volume Safety Equation**

The Green Paper speaks very strongly in respect of a volume/safety or volume/quality equation. It is worth noting that while this has been clearly established to be the case for certain areas of highly complex surgery that this is not the case across the board. 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.

It is an interesting dichotomy that on one hand we are trying to increase the complexity of patient that is managed in the community and spread this experience across a wider platform while on the other hand we are suggesting concentrating surgical experience in high volume centres.

Other factors that require consideration when talking about a volume/safety equation include:

- The volume of procedures undertaken by that surgeon. This should include procedures in both private and public hospitals. For certain procedures the volumes in private will be significantly higher compared with the public sector. In some areas many of the same support staff will be involved in both sectors.
- The training and level of experience of the surgeon is 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 meetings and the decision making that goes around the surgery rather than the surgery itself. Provided the appropriate supports are in place the volume is a poor indicator.
- The Green Paper asserts that all 4 public hospitals in Tasmanian function based on a subspecialist model of care, this is not accurate for all sites. 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 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.
- 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. There is also a cost inherent in such a situation; when a time critical emergency arises the ability of that clinician to deal with that emergency is compromised in a state where transfer of such a time critical patient may take several hours.
- In the case of Upper Gastro-Intestinal and Hepato-Biliary surgery such as pancreatectomy and oesophagectomy, which is specifically considered by the Green Paper, there is a significant loss of patients to the mainland to both the public and private sector. 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.

## **2. Clinical Advisory Groups**

Clinical Advisory Groups (CAGs) have been convened or are in the process of being convened. The opportunity for clinical input into the way in which health services are delivered in Tasmania is welcomed. Some concerns arise around how the governance structure of these CAGs is being implemented. Currently all of these groups perform an

advisory role to the Health Council of Tasmania, which performs an advisory role to the Minister for Health. The manner in which the Health Council of Tasmania is constituted given the membership and the members levels of knowledge and perceived conflicts of interest, raises concerns about how the group will be able to determine priorities between competing clinical interests and in particular about whether precedence may be granted to the loudest group or those with the most cogent argument rather than the group with the greatest need in terms of providing for the Tasmanian patients.

CAGs are not a new creation. They have existed for a long period of time under various different names such as the Renal Network, the Cancer Care Network and a whole host of other identities. They have been variably successful depending on the resourcing and favor of the administration and government of the day. Hence they have come and gone in a variety of iterations.

As the CAGs have currently been constituted, they are convened by Hobart based clinicians in all but one instance (where this was a preexisting committee chaired by a Launceston based clinician). There is also little evidence that there was an open and transparent process by which these groups were convened. There was not an advertised expression of interest and it appears that the process was along the lines of a tapping on the shoulder of certain people. This at the minimum gives the impression of a closed process.

For the CAGs to perform effectively there needs to be adequate representation from all jurisdictions around the state as well as all interested groups in terms of craft and background. Once there is effective representation from all stakeholders it is fundamental that a governance structure is instituted that is effective in facilitating clinical input into the decision making for health services. If this does not occur the clinicians involved will rapidly lose interest as there are many competing demands for their attention. Additionally there is the risk of the CAGs creating unrealistic expectations amongst the clinicians if the CAGs are not an effective vehicle for ensuring the consideration of clinician input into decision-making as they have been sold to be.

### **3. Statewide Waiting Lists**

It is clear that the Minister for Health is committed to the delivery of State Wide Waiting Lists as a means of providing equality of access to services across the state. How this will be operationalised is not clear. The discussion paper on elective surgery remains silent on this issue.

There are a number of aspects of concern in how this aspect is handled. Firstly it is clearly appropriate that there is 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.

If we consider the option of just contributing all of the patients into a central repository and each surgeon drawing their list from that repository then a number of issues arise:

- Not all surgeons will operate in the same circumstances. Individual clinical decision making results in differing thresholds for operating amongst the surgeons even within the 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.
- 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 will invariably return to their place of residence post operatively. The issue arises that when complications occur the patient may have returned to their home. There is a clinical risk with such a scenario as the emergency department and surgeon who are confronted with the case mostly won't have the clinical information available to them (i.e. the operation note) and where they do even the most comprehensive note will not convey all of the information that would be available to the surgeon who performed the procedure. In this situation, 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 best as one can. Obviously this is a less than ideal situation. There are many lessons to be learned in this space 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. This cost is not just in terms of the monetary cost of the travel although this is significant. Other costs are removing the patient from their support network of family and friends 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.

#### **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. Data has traditionally been drawn and used without verification that it is correct and without ensuring that the question asked in drawing the data is actually the question that the person thought that they were asking.

This is unhelpful and draws effort away from working toward the goal of improving the system as a whole. This has led to an air of mistrust and frustration, which is counterproductive. This situation will not simply be addressed by creating a single Tasmanian Health Service. This issue needs to be addressed at a much more basic level. If the New South Wales experience can be learned from in any way, then there is a need to tackle such issues at a base level otherwise no real change occurs as the structure is changed and small area health services are coalesced into large ones only to be broken back down again.

#### **5. The Green Paper has a negative theme throughout**

The Green Paper describes the Tasmanian Health System as underperforming and that there is clearly room for improvement. It is clear that 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 unfortunate that those areas of good performance and standards are not highlighted for the purpose of the paper. It is therefore 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. It is essential that we reform those areas that require it, retain those areas which are functional and do so in a rational 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 some additional funding. Without that additional funding health care rationing will be required as the efficiency 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 disfunctionality 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. This is true for Hobart but even more so for Launceston, Mersey and the North West Regional Hospital. 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.

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. As the private sector is more lucrative and provides access to greater volumes of work, it is this aspect of practice that allows 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 a surgeon's volume it is essential to consider their throughput in the private sector as well as that in the public hospital. For a number of procedures the volumes in private will be significantly higher in private compared with the public sector. This may well make services viable that would not be viable on a public volume alone.

It is encouraging to see 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 training programs run by the RACS 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 RACS is currently investing a significant amount of time and effort in furthering the generalist model 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.

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 development of role delineation and the Role Delineation Framework is wholeheartedly supported. In respect of the trauma delineation framework there needs to be some changes. It is relatively clear from the framework that 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. It is inappropriate to 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 much better result could be achieved by establishing a basis of 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 remain where they are.

The pathway for referral of patients to the appropriate trauma service needs further consideration. 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.

## **11. Vascular Surgery Role Delineation**

Again the development of role delineation and the Role Delineation Framework is wholeheartedly supported. 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.

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 this subspecialty. The scope of practice is appropriately determined by the relevant credentialing committee who may seek advice from an interstate vascular surgeon, as necessary.

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.

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**

The practicalities of travel need to 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 for use and sites are being forced to utilise costly private non urgent patient transport in order to move patients between facilities. The current emergency transfer retrieval system also would require a full review given the delays in and length of the transfer times.

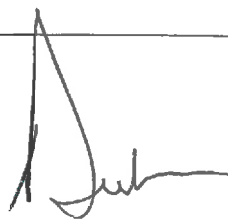


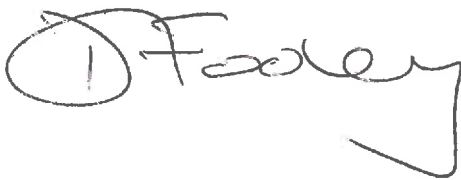
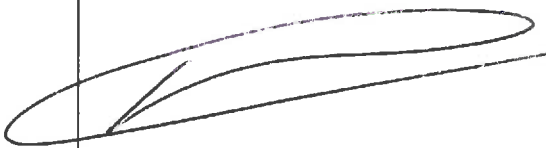


Inherent in any process that requires travel or transfers is the risk of that travel or transfer in and of itself. This is well established in retrieval medicine. This includes the delay in treatment, perhaps less of an issue in the elective setting but definitely an issue in the emergency situation.



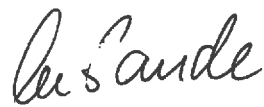




The other issue in relation to transfer and transport is the consideration of the patient's families and how they will be accommodated in areas away from their home base. Patient's families are key to the patients emotional wellbeing and support from family members is essential. Moving services to one centralized area will require some logistical planning and funding to support family members in such situations.

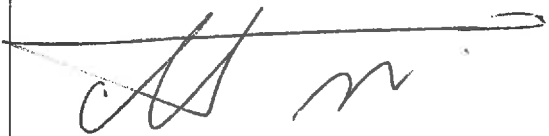



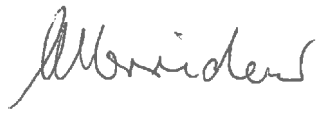


It is essential that capacity be created at the receiving location. This will require significant consideration as there is little spare capacity in any of the major public hospitals and the RHH is about to enter a major capital works project that will further impact on capacity.



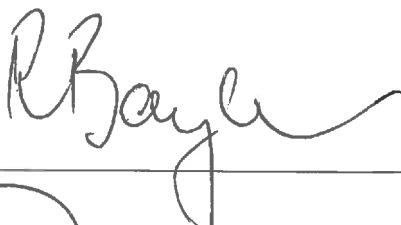
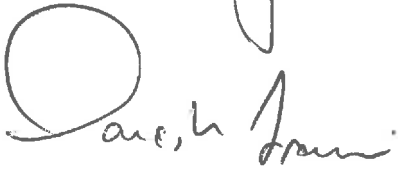


Again the practicalities of deskilling a generalist work force need to be considered as discussed above. This is particularly an issue in time critical situations.

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