Tasmanian Health Organisation – North West

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Hon Michael Ferguson MP
Minister for Health
Department of Health and Human Services

Re: Tasmania ACEM Feedback to Green Paper "One State, One Health System, Better Outcomes"

On behalf of the *Tasmania Faculty for the Australasian College for Emergency Medicine*, I am thankful for the opportunity to provide feedback regarding the Green Paper- One State, One Health System, Better Outcomes. It is a valuable and noble task to reform the current health care system to create one that is more efficient and ultimately provides better outcomes for patients.

I will endeavour to keep my comments brief as I would prefer to emphasize the following key points about emergency care:

- Reform of the existing system is essential. The current status quo does not provide the best care for patients nor is it efficient & sustainable.
- Targeting "GP patients" away from the Emergency Department is necessary but may not substantially reduce the burden of work for the ED. Nor will this fix the root cause of ED overcrowding which is due to access block.
- Co-location of ED and GP services may send the wrong message to the community and result in more inappropriate utilization of ED services.
- Maintaining services that consistently rely on fly-in & fly-out locum services is dangerous
- Consolidation of ED services in NW Tasmania will result in better overall patient outcomes. This will enhance existing services to the NW and provide an improved staffing model that will be consistent and sustainable.
- Patient transportation resources must be adequately enhanced to accommodate an increase volume if services are to be consolidated across the state

I believe the green paper has adequately addressed the current status and explains the need for reform. As was highlighted, better health care can be obtained by ensuring a proper case-mix and volume to ensure clinical expertise. Some patients may be expected to travel a bit further for care but this is more than balanced by the quality of care that will result as a whole. Proximity does not equal quality.

GP Patients in the Emergency Department

Supplement No 4 on Emergency Care puts a lot of emphasis on diverting GP patients to appropriate care and away from the ED. Although this degree of emphasis may not be appropriate, I think this is a necessary undertaking. What many patients do not understand is the ED is not the best place to get good quality GP care. Emergency specialists supervising the management of the department are trained in acute medicine. GP's have a different education and scope of practice. Many ED doctors do not have the knowledge or expertise to manage problems that are best treated by a GP. Therefore GP patients should be strongly encouraged to see a GP.

A recent study published in the Medical Journal of Australia addressed the volume of GP patients that presented to the THO-NW ED's from 2011-2013 *(Med J Aust 2015; 202 (1): 17-18.).* Trying to define exactly what constitutes a GP patient is a challenge. Nevertheless, using the ACEM method they found 35% of the volume during this time constituted GP patients. But this only constituted 7-8% of the total ED treatment time. Regardless of the exact numbers or statistics, I think it is self-evident that there is a substantial portion of ED volume that would be best seen by a GP. But unfortunately this does not have a major impact on ED workload. GP patients should be encouraged to attend their GP because they will get better care. Not because this will substantially decrease the burden on the ED.

The root cause of ED overcrowding is a full hospital where admitted patients are held in the ED. Efforts to enhance the efficiency of the ED should target this access block.

How to best encourage GP patients to seek appropriate care can be challenging without an easy solution. I believe efforts that provide education & incentives to use GP services would be most effective. Currently there is a perverse incentive as the ED is often cheaper and seemingly more convenient to patients. I have witnessed community educational efforts work reasonably well. In addition, availability of routine and after hours GP care is helpful. For example, the overall ED volume at the NWRH has substantially decreased over the last few years. I anecdotally believe this is due to lower acuity presentations going to the successful new GP super clinic located off site but reasonably close the hospital.

As a solution, I do not think that a GP practice and ED should be co-located on-site. I understand that this has been tried at various institutions. The concern is this may change the culture of coming to the Emergency Department and have unintended consequences. The community will gradually come to believe that coming to the ED will get them convenient access to a GP. A greater volume of patients may paradoxically be triaged to the ED. In addition, if the GP services are eventually withdrawn then the ED is encumbered with the extra GP volume. The local culture has changed and people go to the ED for GP care. I believe this is one of the factors resulting in extra GP patients that present to the MCH ED.

Consolidation of ED services in the North West of Tasmania

There are currently two Emergency Departments operating in close proximity in NW Tasmania. The quality of emergency care provided to the overall community would be improved by having one functioning department. Having all genuine emergency presentations under one roof would ensure that patients get better treatment in a consistent and sustainable fashion. Two separate ED's in this small regional area has watered down the existing resources and has made the provision of emergency care challenging.

In order to maintain two separate ED's in the NW we rely on fly-in & fly-out doctors- or locum coverage. Regardless of their qualifications or best intentions, these doctors do not know the local systems and resources available. Within my current portfolio of quality assurance review, I have personally seen adverse events and morbidity due the reliance on locum coverage. I do not think it would be reasonable to expect that locum coverage will be reduced at any point in the near future if we are still staffing two ED's.

The creation of one ED would clearly create more opportunity for enhanced patient care. Increased overall acuity and case-mix would improve. Maintenance and competency of core skills would be strengthened. Access to other acute services would be magnified.

A single in ED would very likely result in additional accreditation by ACEM for advanced training in Emergency Medicine beyond the current 6 months that has been available in the NW. It would be reasonable to expect that this would attract further trainees and specialists to the region and a better department for the whole region.

One might argue that increased transportation times may result in adverse outcomes. It should be emphasized that it would be extremely unusual for a modest increase in transport time to result in adverse events. In the overwhelming vast majority of emergency presentations, some extra minutes do not matter. This is especially true if currently being transported by ambulance personnel. Any consideration of potential harms from increased transport times must be balanced by the greater benefit to the whole community of an improved Emergency Department.

Enhanced patient transportation services

It is obvious that any consolidation of services across the state must come with an increase in resources for patient transport. There is no point have good quality services consolidated in one site if patients cannot get to them in a timely manner. In addition, consideration for other transportation services and accommodation should be investigated.

Yours sincerely

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