Appendix J

Emergency Departments and Emergency Medicine Role Delineation and Green Paper

February 2015

Introduction

The green paper and supplementary papers were publicised on the 8th December 2014. It included the actual green paper which was a summary of the current state with a few figures often presented as fact with a strong suggestion as to how health care in Tasmania should be delivered and the anticipated implications this had for workforce, sustainability, Community, emergency and elective surgery care. There was also attached a large document titled "Tasmanian Role Delineation Framework" this defines what is required in health institutions like hospitals and multi-care centres for the level of health care that can be provided in that structure and what other infrastructure, workforce and connected services need to be present to deliver that care.

The green paper emphasises that it wants to provide *access to better care* rather than *better access to care*. So what is better care?

- Better care is close to home or in the home when outpatient or urgent care services are needed.
- Providing community services such as general nursing palliative care 7 days a week not only to patients already on the books but to new patients that present to the ED or are in the wards that require this care so that they can be discharged from hospital
- It is access to regular health personal who know the patient and has followed their progress over time.
- It is access to specialists who are committed to providing services to Tasmanians and are not fly in fly out doctors.
- It is providing a structure including access to universities and research facilities that encourage the best people to work here and stay here
- It is providing specialised units for complex surgery and medical conditions so that team expertise is maximised and patients have better outcomes even if that means you have to travel out of area
- It is providing the infrastructure such as the right number of beds in all the hospitals to manage the patients depending on their care so that no matter where you live in the state you will be able to access the service you require in a timely fashion without double handling and long waits in several emergency departments.
- It is providing a robust ambulance, retrieval and transport service so that not only can the patient get to the right hospital in the right time frame but the family is able to visit them and there is a means whereby they are able to get back to their home when their acute care is completed
- It is providing accommodation options so that the family can stay close when the patient has to be transferred to another facility or indeed for the patient to stay if they are discharged from non-local emergency department late at night

- It is providing IT structure to support tele-health and a state wide electronic medical record system so that specialists in larger centres can support non-specialist providers in smaller areas to provide your care in your local area
- It is providing accessible information to the public and providers as to what services are available in each area and information on service quality.
- It is about providing a foundation for providing preventative health measures through education and support to decrease community levels of obesity, diabetes, hypertension and depression. This is a generational project that will transcend the political cycle of 3 years

It is stated in the green paper that 30% of the Tasmanian budget is spent on health. This is far too much money to be dependent on political point scoring. A change to the health system must be based on the hard data of what we do, where we do it and how well it is done in combination with the patient story. The system needs to be responsive to changes in these parameters. Changes to the health system take time, often more time than a political cycle of 3 years. If the government is serious about reform it needs to be tri-partisan reform that is continued regardless of who is in government. 30% of Tasmania's budget should not be kicked around in a political game, do that with 1% of the budget if you must but health is too important.

There also was an emphasis on the "health system that we can afford". This is the wrong emphasis. If we structure our system correctly health care costs should stabilise and perhaps in some areas even fall. We should be focusing on quality care in the right place. This is what will give the community the cost savings. We should also be working on preventative medicine and improving the general health of the population realising that the benefits of this work will not be realised for several generations, much like the slip slop slap campaign for skin cancer that has been going for 30 years and is only now showing benefits.

To "focus on the health system we can afford" particularly in combination with a changed role delineation that disproportionally affects the smaller rural hospitals, is to send a message to the rural community that they are too expensive to be cared about. This is not the case. **No amount of money being spent on locums to provide local services for complex problems will provide safe quality care.** That is because quality care is not about the doctor, it is about the team.

There are four areas in the green paper that require further detail. These are:

1. Governance
2. Ambulance, retrieval and transport
3. IT infrastructure
4. Clinical redesign

Governance

The paper states that the government wants to strengthen "the role of the DHHS as the system manager to plan the arrangement, location, type and quality of clinical services". There needs to be a type of matrix management. At the top there needs to state wide agreement of the role delineation and all need to comply with this overall plan and data regarding occasions of service, complexity and outcomes need

to go to the state for review. The state wide committees (CAGs) should also feed into central overseeing body to ensure that craft group services throughout the state are functioning optimally. At the same time there needs to be accountability at the local level with the capacity to respond to local need without having to seek state approval as long as the overall state plan is adhered to. Staff need to feel they belong to a local service. It is hard to feel loyal to a state. They need local managers. In terms of doctors a single director of clinical services in the state would be doomed to fail. Each area needs its local director and governance structure which feeds up to a higher level. Without this many staff will feel disempowered and helpless which will not lead to quality care. I would imagine that all craft groups will have the same issues.

Transport, Ambulance, Retrieval.

With the new role delineation that is being developed it is clear that more complex patients will be managed in Launceston and Hobart. The patients that live in Launceston and Hobart will not have to travel but there will be an increased burden people who live in other areas. The burden is not only on the patients but also on their families.

If the state mandates health service role delineation then it is also incumbent on the state to provide the following:

1. A clear ambulance bypass policy for the state that is well communicated to the public and the hospitals which states which hospital the patient will be transported to. This policy should be based on the role delineation of the hospital and patients should not be transported to any hospital that does not have the capacity to manage them. This will reduce inter-hospital transfers and the increased morbidity and mortality that this produces. This policy should be based on the data and be reviewed regularly.
2. A transport system for the patient and their families so that after their acute care is provided at a non-local hospital they are able to return to their local area in a timely fashion and within a reasonable cost
3. An accommodation system such that patients and their families can stay if they are discharged from a non-local hospital late at night after their acute care has been completed. This particularly affects patients that are transferred from one ED to another for an expert opinion and they do not require admission after assessment. This often occurs after hours and there is no way for the patient to return to their local area
4. An enhanced bus/other transport service so that the families can visit their relative easily. This is extremely important in the north west as many of our patients have low incomes and travelling out of area is a significant burden
5. Expansion of the current accommodation provided.

Currently just the transfers from MCH cost $130 000.00 per month or about 1.6mil per year. Many of these could have been avoided if the ambulance took the patient to the higher care hospital in the first place. Also at MCH we have had changes to the inpatient services provided and this has necessitated an increase in transfers. No

increase in resources was provided for this and no analysis of the beds required at the higher care hospital (NWRH) was done. As a result there were long transfer delays (up to 6-7 hours mean about 3-4 hours) and increased access-block in the NWRH ED as well as increased frustration by patients and their families about how to get back to their local area. This could be repeated at a state wide level if there is no robust analysis of the transport needs and the number of beds required in each hospital with the change of role delineation.

It is my opinion that in this reform process that the issues of transport for the patient and their families and ambulance resourcing be one of the first areas if not the first area that needs to be addressed. This will give something tangible and desirable to the community and will allow acceptance by the community for the change in role delineation as they will feel confident that they are not only going to be able to access better care but will also be able to get home.

Information technology infrastructure

While the green paper and it supplementary documents is focused on service delivery change it is very important to remember that IT infrastructure is integral to delivering a safe service to patients.

Over the past several years there has been a loss of investment in this very important area of health provision. There is a connected care strategy for health information but due to lack a lack of finding over reliance on commonwealth funding (which finds specific projects rather than progressive integration) and changing priorities there has been a significant disconnect between IT and health.

If the proposed health delineation changes come into effect it will be essential for clinicians to be able to access the entirety of the patient's medical record regardless of where in the state that patient is being assessed by the clinician. There should be ready, easy and portable access to secure telehealth so that remote consultations can take place to aid non specialists on the management of patients close to home and that this consultation can become part of the medical record so that true shared care can occur.

Electronic records allows for better data collection so that staff, patients and managers alike can review their work output and processes so that changes can be made to improve the patient journey and be responsive to the patient needs. Currently we have a lot of data in raw form but it is difficult to use this in a constructive manner clinically. The business intelligence unit based in Hobart and the North West has come some way in addressing this and should be expanded to provide all clinical units with meaningful data on their work.

Without the right data we cannot provide the right service.

Clinical redesign

In order to provide access to a better service we need to redesign how we provide care. All clinicians know **what** care to deliver to their patients but many do not understand process issues in delivering that care and even worse have no measures that are meaningful and available on a daily basis so that they can review their processes. The UTAS clinical redesign project that is currently being run is a fantastic opportunity to improve how we do things. It is absolutely necessary that this process be done before the role delineation is changed. All efforts to reform the

health system to ensure good care in the right place will fail if we do not get the bed numbers right in all the hospitals, if we do not get the transfer of patients from the ED to a ward bed within 4 hours, if we do not aspire to ensure that each patient will only experience one emergency department visit for each episode of care, if we do not ensure that community services are available 7 days a week to support the family in looking after the patient at home. It would be better to change nothing than make a role delineation change without doing this groundwork first.

Role Delineation

Attached to this document is a spread sheet that uses the green paper role delineation framework and attempts to assign a level of service for each facility in the state. You need to read this attachment using the role delineation framework that has been developed. I have done this using my local knowledge and have consulted a few people. I must stress that this body of work is my opinion. The reason for sharing this with you is to give you a framework for discussion.

In summary I think the role delineation should be as follows:

Rural facilities: urgent care and some subacute inpatient care run by GPs or nurses with access to some point of care pathology and medical imaging who can provide basic and advanced life support in an emergency. All patients requiring acute care to be transferred. They should have access to specialists for advice. Ambulances should not go to these facilities except for palliative care or as designated by a FACEM at their referring hospital

Mersey Community Hospital:

- Urgent care centre 24/7 run by CMOs, GPs and Nurse practitioners with education and governance by FACEMS from NWRH.
- A six bed short stay unit run adjacent to the urgent care centre.
- No ambulances to go to MCH unless palliative or have a mental health issue.
- Gazetted mental health unit
- No acute inpatient care. All acute medicine, surgery, paediatric, gynaecology and all planned births to be transferred to a hospital with the appropriate role delineation for the patient's condition.
- Antenatal and inpatient post natal care
- Inpatient management of patients requiring palliative care and rehabilitation medicine,
- Outpatient clinics for many sub specialities.
- Cardiac, respiratory and falls clinics
- Day surgery for the north and north west, including orthopaedics, general surgery, endoscopy, cardiac investigations, ?ENT

North West Regional Hospital:

- Emergency department with 6-12 months accreditation with FACEM coverage on site 16/24 and on-call after these hours 7 days a week.

- 4-6 bed short stay unit adjacent to the ED
- Inpatient services for acute medicine, general surgery, orthopaedics, Paediatrics, Gynaecology, All planned births for the North west greater than 34 weeks
- Outpatient clinics for many sub specialities
- Multiday surgery for conditions that are level IV or below
- Emergency surgery for stabilisation prior to transfer
- Level 4 ICU with up to 24 hours of ventilation which is run with a combination of Intensive care specialists and other critical care specialists with an interest in ICU such as emergency and anaesthesia

Launceston general Hospital:

- Level 5 hospital in general. Covering emergency and acute inpatient care in general medicine, surgery, paediatrics, obstetrics, gynaecology and some sub specialities (cardiac with reperfusion service, respiratory, gastroenterology, ENT, plastic surgery and there may be others).
- Level 5 ICU
- It does not include inpatient services for neurosurgery, cardiothoracic surgery, burns unit, neonatal intensive care, hyperbaric medicine
- Outpatient clinics
- Multiday complex surgery, some day surgery

Royal Hobart Hospital:

- Level 6 hospital
- Level 6 Emergency service
- All inpatient services except spinal cord injury and complex neonatal surgery
- Complex multiday surgery
- Level 6 ICU
- Outpatient clinics

Emergency Medicine

I have left this till last as there are some specific issues that impact more on the ED than any other area. The most important issue is that of access block in our Emergency Departments. This is often seen as an ED problem but in fact is the result of the entire health system not doing its job and the result is patients backed up in ED.

Access block is the result of the following:

- The inpatient bed numbers not matching the number of patients requiring them in all the hospitals
- Poor processes in the hospitals which block flow of patients from the ED to the ward, to imaging, to theatre and back out to the community

Access block is NOT due to

- Too many GP patients.
- Poor processes in the ED

The green paper asserts that 43% of the patients coming to the ED are avoidable presentations or GP type patients. Over the years many people have tried to work out what a GP type patient is. This is all done in retrospect and based on what we the clinicians think. The real issue is what does the patient think. When you ask the patients, they state they come to the ED because they think their problem was an emergency or there was no other health provider. The GP type patients however you define them do not cause overcrowding in the ED. They only take up 7% of the treatment time in the ED. The rest of the time the admitted patients need the care. Trying to address ED access block by focusing on the GP type patient in a waste of time and will not address the problem.

In regard to community services being more available to prevent ED presentations again this is not where the workload is. When patients with multiple health and social issues present to the ED they usually require a full medical and social workup. This is very difficult in the community because urgent access to pathology and medical imaging with on tap specialist consultation is not available within the 2 hour window that it is in the ED. Very often these patients require an inpatient stay to optimise their functioning. Where the community services are required is at the inpatient side so that they can be discharged early to free up the inpatient bed. It does not save money, time or resources doing something in the community that takes weeks that can be done in the ED with a short inpatient stay in 24-48 hours.

I hope I have covered everything here. I am happy to take feedback (constructive). I do not have all the answers but just wanted to provide a template for discussion.

Author:
Dr Marielle Ruigrok
Director of Emergency Medicine
THO-North West

January 2015