Appendix C

Future role delineation options for North West Regional Hospital Green Paper response against proposed role delineation guidelines

January 2015

Introduction

There is some very sensible dialogue put forward in the framework but I will concentrate on comments/concerns/criticisms of the documents to keep it concise.

It is essential that any health service is clear on the level and type of services it is delivering and the resources needed to do that, to facilitate safe, quality, affordable care for patients. It is widely recognised that a role delineation framework is an essential tool in being able to achieve this and the government should be applauded in developing one.

The working draft One State, One Health System, Better Outcomes, Tasmanian Role Delineation (framework) is taken from a mix of several Australian models and adapted. Whilst this is logical, as we need to consider the Tasmanian context, it is important to understand that care across Australia should be consistent, the clinical capacity of care in health services should be the same for the same cohort/service delivery and not contextualised to what we have/do, but what we should have/do.

The framework does not easily translate to all service delivery. Cancer services particularly are seen as a service that should be integrated and separating out each service does not fit well in determining the service delivered.

North West Regional Hospital (NWRH) General comments

NWRH operates as a generalist hospital in most ambulatory and admitted services. There are specialities in some areas by medical officers employed by THO-North West such as medically endocrinology, gastroenterology and oncology, and surgically ENT, O&G, ophthalmology, and orthopaedics. Within the surgical specialities, complexity varies with surgery at NWRH. Transfer of patients from the NW occurs to Launceston General Hospital (LGH) and Royal Hobart Hospital (RHH) to access speciality areas not delivered at NWRH. There are some interstate transfers. Outpatients is a busy area across many specialities delivered by our staff or outreach. Paediatrics particularly delivers most care in the outpatient setting. Other outpatient specialities are delivered by outreach from within Tasmania or interstate via Tasreach.

Services have been established in relation to the local population, which is just under a quarter of the state and very similar to THO-North population. As the NW is geographically, the most spread out, important considerations in service model development has been service capability in the area, travel times, transport availability. Not unique to the NW is that the community wants, where possible, local services.

NWRH needs to be considered in the context of Mersey Community Hospital. There is opportunity for each hospital to have its own unique set of services with minimal duplication. There is also opportunity to consolidate some services at a state-wide level and the hospitals become a centre of excellence. NWRH has a new rehabilitation unit that has opportunity for developing excellence in acute stroke management. Medicine could have opportunities to develop specialised services such as diabetes management whilst surgery could be delineated at a state-wide level for certain diagnostic groups.

NWRH service models consider capability to deliver local services and has considered carefully, in the past, capacity for sustainability and safe, quality affordable care. This has been challenging at times particularly regarding a sustainable workforce. THO-North West has already begun delineation of services between MCH and NWRH to improve sustainability, decrease duplication, and improve safety and quality of care.

NWRH has been placed as the regional hospital for the NW and it is the view that this should remain the status. In the delineation, framework support services such as ICU/HDU to support complexity of services and cores services, such as trauma, are seen as crucial areas in the current service delineation for NWRH, without major change to the system particularly in regards to acute transport.

Current issues of workforce sustainability require some critical thinking and strategic planning to enable deliver of safe high quality services now and in the future.

Chronic pain services, palliative care and drug and alcohols services are currently at an insufficient level in the north west and should be expanded. The better access to palliative care is seeing an improvement in palliative care service delivery that may rectify this.

Role delineation will determine service level delivery but there will always be a need to some patients to be transferred in/out. Access to up to date clinical information is essential and investment in an electronic state-wide medical record so that true shared care can occur should be a priority in supporting safe high quality care. At present, a digital medical record is in place in the NW and South. The north should invest in this if an electronic medical record is not forth coming in the short term.

Telehealth also needs investment and an electronic medical record it will assist this service delivery. This requires investment in people and systems to enable it to function efficiently. Telehealth co-ordinators should be appointed in each health area. Telehealth can assist the generalist practitioners manage more complex patients in their local area. For example managing acute renal colic in conjunction with urologists and chronic sub-durals with shared care with neurosurgeons in Hobart and General surgeons in NWRH.

Role delineation feedback

Background

P 5 " When applied across the state, a consistent set of minimum standards and requirements for clinical services… in public health services .There is no community or primary service delineation attached. I realize that this is focused mainly on acute health with limited community services but maybe a paragraph on why it wasn't included would have not undervalued those sectors not picked up. They are an important part of the system.

P5 Underlying principles

Dot point 2- minimum service volumes is named as a contentious issue by some medical officers in determining what is considered low.

Dot point 3 – consideration of proximity should not be the defining reason for service delivery but it should be recognised that this is a considerable factor for the community and transport and accommodation is not the easy answer to solving the problem. It is also about the families' ability to support the patients and when they are not in the local areas; time of work etc can be difficult. It is known anecdotally that patients made decisions on whether to have radiation therapy based on travel and opted out when life commitments made it too difficult and chose more radical

surgery in some case for example Mastectomy verse lumpectomy. Community context cannot be understated but should not dictate, as safe, quality service delivery is paramount.

Dot point 4 - Sustainability of workforce is an area that NWRH has challenges in to ensure effective safe service delivery particularly with specialised areas such as ED and ICU/HDU. On call rosters for some medical specialties are from 24/7 7 days a week (ENT) to 1:4/5. Redesign must look at the need of the service and for specialities with high frequency ratio for on call roster allocation. There needs to be scope at North West Regional Hospital (NWRH) to consider this and review services delivered.

P 6 - "The role delineation service levels are cumulative …It is intended that there is a level of flexibility between the margins of the levels". This can create tension when operating between two levels as complexity is the key ingredient with matched resources. Between levels risks over/under resourcing on one aspect of the level and does not ensure safe quality care. It should always drop to the lower level when only some of the next level is available. If between levels, it should prompt a review of the service to determine the appropriate level.

P 7 para 2 – definition of networking is unclear and use of within the network in the document is not clear, as to whether it is within the current THO, another THO or state-wide.

Assessment of NWRH service delivery capabilities against proposed role delineation guidelines.

1.0. Clinical Support Services

Each support and core service has been reviewed with heads of departments and with majority agreeing with the assessment below. There is some sensitivity in the areas of ICU/HDU and surgical services role delineation. Specific clinicians will most likely feedback directly their thoughts on this. It is understood that the Clinical Advisory Group (CAG) for surgical services are working through delineation of surgical services as are other CAG's.

Services have been assessed as at current level with some commentary.

There is comment from clinicians that the level and associated level of support services do not always match what is necessary to support the cores service level and should be reviewed. As there is varying opinions in this rather than name specifics a general review is asked for.

Clinical Support Service	Proposed role delineation level	Key referral/clinical network site/campus where required
Anaesthetics	Level 5- All criteria met. Complexity is usually related to the emergency patient. This should remain to meet emergency demand of the regional area.	LGH, RHH
Intensive Care / High Dependency Unit	Level 4 (aka Level 1 as defined by CICM) - All criteria met- on occasions with multisystem support for patients for longer than 24 hours (level 5) but majority of care is level 4. Level 4 would be the preferable level to support other core services at NWRH that should remain clinically. Sustainability of resources at level 5 would be an issue in relationship to workforce particularly. This unit is	LGH, RHH

Clinical Support Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	very dependent on the core service elective surgery providing complexity of patients to ensure that skills and knowledge is rehearsed rather than reliant on emergency patient's admissions only. A High Dependency Unit would not support core service delivery of emergency cases that NWRH is the receival hospital for. *Possible delineation between NWRH and MCH* All HDU patients are at NWRH	
Pathology	Level 4 - All criteria met with many aspects of level 5. Currently a contracted service and whilst there may not be a fulltime pathologist in the NW there is access to one in the pathology organisation in the State. The service provided is excellent that meets clinical service delivery needs.	LGH, RHH
Pharmacy	Level 5 -with possible clarification on: A medicines/drug information service provided for the whole of the network and state – we don't provide for the whole state – this is done through RHH This requirement seems to be contradictory to the dot-point above it. Comments on the criteria: P 19 under heading "Pharmacy Services" Pharmacy services provide……information and governance on appropriate utilisation of	State wide

Clinical Support Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	drugs…… (Pharmacy Management should have representation or chairmanship of Drug and Therapeutics Committees and input into medication policy) "…..membership on hospital-based network committees…." Is mentioned at Level 3 (p20) but not really expanded on at higher levels. Something like "Direction to" or "Input into medication governance and medication policy at D&TC, Quality Committees and Clinical Governance Committees" at Level 5 would be good. There is no change to the level of manufacturing service for extemporaneous manufacture for Levels, 2, 3 , 4 & 5. I am not sure what the term "basic" means and seems to apply to all. I think get rid of the word "basic". At Level 5 "limited small batch manufacturing" for any hospital really implies full TGA registration as a manufacturing facility to be able to produce "batches". Most hospitals (unless they are Baxter or similar compounding facility) would only be able to do individual compounding for any product whether sterile or not. "Non-sterile, extemporaneous individual compounding and sterile individually compounded products ……..." would be better.	
Radiology	Radiology and Nuclear Medicine are provided by two different organisations. Radiology is a contractual arrangement and is	LGH, RHH

Clinical Support Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	level 5 and meets all relevant criteria with exception of specialised interventional radiology. Nuclear medicine criteria with level 5 are met with the exception of, on call 24/7, single-photon emission CT (access is available in Launceston) and medical specialist not always on site but always available for consultation 24/7. NWRH does not have a contractual arrangement with the nuclear medicine provider.	

2.0. Core Services

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
Emergency Medicine	Level 5. All criteria met. This should remain level 5 as a regional service. It has appropriate support services to support as well. *Possible role delineation between NWRH and MCH* NWRH accepts all ambulance patients MCH is an urgent care centre	LGH, RHH
Trauma Services	Level 4. All criteria met. Should remain at level 4. Multi-trauma should be stabilised in the ED and transferred to a trauma centre.	LGH, RHH
General Medicine	Level 5. All criteria met. In the NW, we have a	MCH, LGH, RHH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	generalist medical service with subspecialty interest. Currently we have general physicians with interest in endocrinology, gastroenterology, respiratory and cardiology medicine. This may change over time but no pure speciality service exists in the north west, which is appropriate for its role delineation. *Possible delineation between MCH and NWRH* Acute general medicine should be managed at a single hospital in the north west. Acute medicine to meet its level 5 role delineation needs to have the support services of general surgery and ICU/HDU. These cannot be supplied at MCH and hence all acute medicine should be admitted to the NWRH	
Integrated Cancer Services	This service delineation needs a review in line with current and proposed services in the State. There are aspects of an integrated cancer service at level 5 at NWRH now and in the future with establishment of a radiation service. This is not a straight forward delineation to assess. It does not operate on the premise of integrated cancer care. • Medical oncology - Level 3 with most aspects of level 4. NW oncology patients are admitted under a	LGH, RHH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	physician with a medical oncologist consulting. Inpatient chemotherapy may be done in isolated cases but not as a routine. All other criteria in all other areas met. This model has provided good clinical governance. • Radiation Oncology – Level 4 -all criteria met except on site radiotherapy which will be established in 2016 which fits within level 5 • Haematology - Level 4 - all criteria met • Clinical trials - Level 4- all criteria met	
Cardiology Services	Level 4- All criteria met with grey areas of outpatient area consultation by cardiologist as NWRH has a physician with a special interest in cardiology.	LGH, RHH
Endocrinology	Level 5- All criteria met. Should remain at level 5 due to demographics and burden of disease in NW	LGH, RHH
Gastroenterology	Level 4 - All criteria met but patients are admitted by a physician with gastroenterologist consulting. This model has been in place for several years. Should remain at level 4	LGH, RHH
Infectious Diseases	Level 4- All criteria. Sexual health nurse is DHHS appointed and is accessed by THO-NW. MCH, NWRH	RHH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	and Primary Health Services share resources across the north-west region	
Neurology	Level 3- All criteria met- Some aspects of level 4 but visiting medical specialist is monthly outpatients only. ? thrombolytic therapy for patients with stroke should be a defining factor for the level delineation when clinically this is debated. Should consider whether level 4 when clear on criteria.	LGH,RHH
Renal Service	Hospital – level 3 – all criteria met – dependent on plan for renal services NWRH could become level 4 and take over renal service for NW if able to recruit nephrologist.	Community – level 2 –all criteria met - service under control of THO-North.
Respiratory Medicine	Level 4- all criteria met- meet aspect of level 5 as bronchoscopy services are available, but should remain at level 4 as workforce sustainability of respiratory physician is challenging.	LGH, RHH
Rheumatology and Pain Management	No current public service- this is a gap for chronic pain management and needs to be addressed. ? the two areas should be linked. Not all chronic pain is rheumatology related.	LGH, RHH
General Surgery	level 4- all criteria met- aspects of level 5- regional referral role and we do emergency surgery of SCV. ? Interventional cardiology should be in under general	LGH, RHH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	surgery. It is a specialised service. Most of our elective surgery is at level 4. Need to be at a minimum of level 4 with appropriate resources to offer emergency surgery as is needed in a regional area and to maintain skill of ICU/HDU staff.	
Cardiothoracic Services	Nil services and should not be delivered at NWRH as a highly specialised service.	RHH
ENT	Level 4- all criteria met and some aspects of level 5-. Noting there is no on site plastic surgery service or radiation oncology treatment but radiation oncology outreach outpatient's consultation. This will change in 2016 when radiation oncology service established in the new cancer service.	LGH, RHH
Gynaecology Service	Level 5- All criteria met- should remain at this level with some consideration of the complexity under this level at NWRH. *Possible delineation between NWRH and MCH* All surgery from level 1-4 could be done at NWRH and day surgery at MCH. There is an opportunity to expand here with urodynamic service, which would be an opportunity for the NW. There will be an increasing demand for this service	LGH, RHH
Ophthalmology Services	Surgery contracted to North West Private Hospital and	NWPH, MCH, LGH, RHH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	referred to MCH. No inpatient service as a rule with a state based on call system for emergencies. Have very good local ophthalmology practitioners that provide an excellent service. Current service should remain	
Oral Health Services	Not a NWRH service	Access to state-wide service. NWRH has an oral health unit on site.
Orthopaedic Services	Level 3/4/5 – all criteria met for level 3 but not an accredited orthopaedic training site level 4 requires and level 5 we have on call orthopaedic surgeons but ? on "…full range… definition for on call orthopaedic surgeons.	LGH, RHH
Plastic and reconstructive surgery	Nil service and not suggested that there should be. Access via LGH and RHH service.	LGH, RHH
Urology Services	Nil service	LGH,RHH
Vascular Surgery Services	Nil service	LGH, RHH
Neonatology Services	Provide neonatal care day 9 and above in Paediatric ward –Level 3- under general paediatricians if suitable for admission.	LGH, RHH
Maternity Services	Contracted to North West Private Hospital	LGH, RHH
Paediatric Services	Level 3 – all criteria met but aspects of level 4 as NWRH has a regional referral role and designated paediatric allied health but no specialist nurse director and ? this is	RHH, LGH, RCH

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	required at level 4 care, specifically for this area. This type of role is not mentioned in any other role delineation. Delineation of complexity is not clear in this service. The support services appear to designate the level of complexity. Should be a level 4 service at NWRH? ICU/HDU level 5	
Paediatric Surgery	Level 3- All criteria met and should stay at this level.	
Drug & Alcohol	No service provided by NWRH	Limited access to referral service on NW. Access to services at a minimum level 2? level 3 by referral
Geriatrics	Level 4 – All criteria met- some aspects of level 5 in that rehabilitation unit on site, some clinics, but capacity to up resource to 5 should be considered as NW has the oldest population in Tasmania. This is a subspecialty of medicine and acute geriatrics should be managed at NWRH as it has the support services but if subacute and requiring rehab and subacute assessment then MCH could deliver this service.	RHH for psychogeriatric
Mental Health Services	Inpatient Unit at level 5-All criteria met ?need level 5 pathology support service. ? does this unit need to stay at NWRH or transferred to MCH Inpatient unit could be managed at MCH with medical consultation	RHH for psychogeriatric and specialised Paediatric inpatient

Core Service	Proposed role delineation level	Key referral/clinical network site/campus where required
	available and with a 24/7 ED presence Currently inpatient unit for adults only and paediatrics are managed in general paediatric ward with support from MHS. This is not an ideal clinical situation for all patients.	
Palliative Care Services	3 palliative care purpose built inpatient rooms and support area for visitors	Access speciality service in THO via community based service
Rehabilitation Services	Level 4- All criteria met with exception of step up/down beds. Delineation of this service for NWRH should not be reliant on step up/down beds. Need to determine role within state services. ? role of MCH of rehabilitation in sub-acute setting in an inpatient and step down unit	

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