Tasmanian Government

Tasmanian Health Organisation – North West Response to Delivering Safe and Sustainable Clinical Services – Green Paper

The Government's vision is for Tasmania to have the healthiest population in Australia by 2025, and a world-class health care system where people get treatment and support when they need it. The challenge as mentioned in the Green Paper is Tasmania's small population base, limited resources, capacity or capability to maintain the full range of clinical services in Tasmania in a way that is safe, reliable, effective and sustainable.

In summary, Tasmanian Health Organisation – North West (THO-North West) understands that a substantial portion of the Tasmanian Health Budget is consumed by administrative costs and that this needs to be addressed and recommends a complete review of the administrative processes and a rationalisation of all areas be undertaken, in order that more of the health funding gets spent where it is required. The review should also include the revision of the Tasmanian Work Practises Legislation to enable it to function more like the private sector for example ensure that people can be dismissed for inappropriate performance and or behaviour.

In the foreword of the Green Paper, Minister for Health Michael Ferguson clearly states "this reform is not about cutting services", and we should ensure this undertaking is adhered to.

THO-North West agrees it may not be practical to provide a Level 6 hospital in Hobart, Launceston, Devonport and Burnie in the future. While not written specifically in the Green Paper, on Page 18 and 19 it refers to the various levels of hospital complexes, and from discussions with interested parties, the THO understand there may be a view that the Royal Hobart Hospital (RHH) should be a Level 6, Launceston General Hospital (LGH) a Level 5 and North West Regional Hospital (NWRH) a Level 4 hospital and there may well be justification for this given the population of Tasmania.

THO-North West believes if NWRH is to be a less than a Level 6 hospital, that there should be exceptions and that NWRH should maintain some of the established practices and capability that already exists on the north west, as to do otherwise would unnecessary disrupt the public and health practitioners, professionals for example established services such as paediatrics and orthopaedics.

There needs to be an urgent push to resolve the North West Private Hospital Maternity Contract and have this reverted to the public health system so that the safety and professionalism of this service can be assured and the financial benefits flow to other more urgent medical needs.

There needs to be an appropriate clinical oversight committee established, that is able to take swift and decisive action in relation to inappropriate practises or behaviour of clinicians and health professionals, regardless of the level.

As an overall comment, there is a need to ensure the NWRH maintains a level of service, a level of emergency services, intensive care and capability as it is a central facility to the West Coast and north west communities. The THO, does however concede that more serious cases as is the current practice, are

moved to LGH and RHH as appropriate. The current level of services provided would be a reasonable benchmark for the future once the current challenges and issues are resolved.

We note in Page 11 that the waiting times for Tasmania are substantially higher than other States but we would suggest this is more about money than capability of our health systems. Before the current monetary crunch on the hospital systems, our waiting lists in the north west were amongst Australia's best.

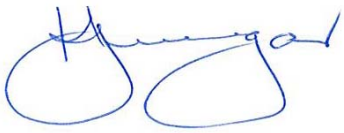
It is assumed the Cancer Centre will continue to be completed and operate as planned and a budget provided for its full operation.

In addition, central to the success of the reform process Government must:

- Ensure the extensive and long term changes proposed in the Green Paper and Role Delineation Framework have political commitment to see them through.
- Ensure that 'access to better services' is ***equitable.***
- Address both the jurisdictional divide in the collection and distribution of funding and consolidate the mechanisms currently used for funding allocation.
- Consider and include primary care providers in its service planning as they are part of, not separate to, delivery of health services to Tasmanian communities
- Ensure capital planning of hospital facilities and planning of services at area/regional and State level is coordinated with the implementation of the *Tasmanian Role Delineation Framework.*
- Ensure over-centralisation of services does not occur as evidence indicates this would unfairly disadvantage those living further from the specialist service nucleus. Meaning those living in Tasmania's remote and rural areas could pay more personally to access publicly-funded health care services.
- Regularly review the Patient Travel Assistance Scheme (PTAS) funding model as part of the *Tasmanian Role Delineation Framework* implementation.

This response has been developed through the THO-North West Executive and endorsed by the THO-North West Governing Council and has been submitted in the following format for simplicity:

- Tasmanian Role Delineation Paper – Draft
- Green Paper – Other Services Considerations A – Z
- Supplement No 1 – Sustainability and the Tasmanian Health System
- Supplement No 2 – Tasmania's Health Workforce
- Supplement No 3 – Building a Stronger Community Care System
- Supplement No 4 – Emergency Care
- Supplement No 5 – Elective Surgery
- Green Paper – Set Questions
- Acknowledgements.



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Acting Chief Executive
Tasmanian Health Organisations – North West

18 February 2015

Tasmanian Role Delineation Paper - Draft

The strengths and weaknesses of the role delineation model proposed are well evidenced as the frameworks focus is on inputs, rather than desired health outcomes.

It is useful for co-ordinating services within an area and also provides benchmarks to compare services offered between different areas. However, the model is unable to evaluate the competency levels of staff, other than obliquely through assessing the frequency with which they perform certain procedures and it would also be inappropriate to be used as a purchasing tool as purchasing is ideally output focused.

Allied Health Services

THO-North West is concerned the role delineation paper remains silent for services relating to Allied Health Services (AHS). This service provides clinical expertise to most of the medical areas documented and it has a direct impact on service delivery and patient care including preventing complications, reducing length of stay and preventing admission to hospital.

AHS provide inpatient, outpatient and community services to children and adults within Tasmania. The level of allied health service provided by a health facility reflects the acuity of the patient and the number of acutely ill patients and highly complex cases treated. Specialised outpatients service is also a reflection of the complexity of the patient load in an area.

It should be noted that facilities that provide acute services are also providing regional and remote service within their current THO structure. For example a service with acute services at a level 6 may also provide outreach service to a level 3 delineation description.

THO-North West recommends that the AHS be listed as a clinical support service within the Tasmanian Role Delineation Framework as follows:

Level 1 Allied Health Services

Service Description

A Level 1 service provides services on an outpatient basis to a local community.

Service requirements

- Ability to provide formal and informal training to other health professionals and ancillary staff on relevant clinical topics
- Appropriate networking with higher level services
- Links to other relevant services to support patients (e.g. community nursing services)
- Telehealth facilities where this has been identified as a means of providing clinical services and oversight
- A reliable internet connection with sufficient capacity to enable access to receive consultation from a higher level service
- Defined and appropriate supply chain.

Workforce requirements

- Access to allied health professional where not on-site

- Access to registered medical practitioner and or nurse practitioner (NP) for facilities in rural and remote areas
- Access to on-site registered nurses
- Undergraduate and postgraduate allied health training roles
- General or junior level allied health staff are mentored or clinically supervised by specialised or advanced-level practitioners where applicable
- Referral pathways to access complementary services as required for patient care (i.e. access to interpreting service).

Level 2 Allied Health Services

Service Description

A Level 2 service provides services at a Level 1 plus it provides an inpatient service by referral – inpatient services may be visiting. Services may also be provided to patients in their homes via community allied health services.

Service requirements

As for level 1 plus:

- Clinical services for outpatients via an outreach service, community patients via a home visiting service, and inpatients may be provided with service by referral and seen via a visiting outreach service or through Telehealth AHSs if available
- Appropriate networking with higher level services
- Undergraduate and postgraduate allied health teaching roles.

Workforce requirements

As for Level 1 plus:

- Access to allied health either visiting or occasionally on-site
- Access to a more specialised allied health service from a higher level facility within the State
- General or junior level allied health staff are mentored or clinically supervised by specialised or advanced level practitioners where applicable.

Level 3 Allied Health Services

Service Description

A Level 3 service provides services at a level 2 plus an on-site weekday service for inpatients and outpatients.

Service requirements

- Clinical services for inpatients, day patients and ambulatory patients in specialised and discipline only clinics
- Provides support to outreach and specialised services
- Clinical services include assessment, intervention, consultation, discharge planning, equipment provision, education and support, advocacy and referrals to community services

- Provides equipment via the TASEQUIP process and sites at Level 3 act as stores for this equipment. Satellite stores may exist at other lower level sites but are coordinated via this site.
- Timely access to clinical information, including medical records and pathology results, reliable access to dedicated desktop and to laptop computer in ward / clinical areas, or equivalent (e.g. electronic tablet), if wireless technology is available
- Has responsibilities across a defined area within the region, providing support and service oversight to lower level services through intermittent visits, via outreach or Telehealth AHS if available or through other means
- Appropriate networking with higher level services.

Workforce requirements

As for level 2 plus:

- Services provided by a team that may include allied health professional, allied health assistant and administrative support.
- Allied health professionals available during designated business hours. Documented processes in place to access information outside of these hours (i.e. after hours service may be provided by a higher level service under a documented process).

Support service requirements

Path	Rad
3	4

Level 4 Allied Health Services

Service Description

A Level 4 service provides services at a level 3 plus it provides services with some capacity for after hours for some service areas.

The service is able to provide care for a full range of patient risk levels, and has the capacity and capability to care for patients that are likely to have complex and competing therapeutic needs, and multiple comorbidities that the service must consider when optimising therapy.

Service requirements

As for level 3 plus:

- Services provided to inpatients and ambulatory patients as part of specialised clinics
- Provides consultation and accepts referrals from lower level services within the State
- Provides support for a range of speciality services (e.g. persistent pain service)
- Provides visiting services to lower level services within the Region / State
- Provide a range of speciality outpatient services (hand therapy, paediatric feeding, orthopaedic pathway services, seating clinic, universal hearing screening, paediatric continence clinics, and high risk foot clinics).

Workforce requirements

As for a level 3 plus:

- Provision of weekend and after hours services for some service areas
- Allied health teams are structured to deliver services at multiple levels throughout the organisation
- Allied health work in interdisciplinary, multidisciplinary and single discipline services.

Support service requirements

Path	Rad
3	4

Level 5 Allied Health Services

Service Description

A Level 5 service provides services at a level 4 plus it has capacity to act as a referral service for very high-risk patients except those who need high level specialised clinical services, such as highly complex patients.

Service requirements

- Provision of capacity to lead and contribute to quality and safety of complex clinical care across individual services, organisational and systems level services
- Inpatient services work within scope of professional practice for the allied health discipline
- The capacity to respond to requests for allied health intervention related to direct patient care in a timely manner, either through an interdisciplinary or multidisciplinary approach.
- The service may actively participate in multidisciplinary research.

Workforce requirements

As for a level 4 plus:

- Provision of weekend and after hours services for some service areas
- Provision of oncall services for specified areas such as Emergency Department (ED), acute medicine units, and ICU
- Allied health teams are structured to deliver services at multiple levels throughout the organisation
- Allied health work in interdisciplinary, multidisciplinary and single discipline services
- Specialised allied health positions which reflect the range of clinical services provided (e.g. ICU, paediatric neonates, oncology, burns, neurology, neurosurgery and rehabilitation).

Support service requirements

Path	Phar	Rad
3	3 (pending prescription	4

	rights for podiatry)	

Level 6 Allied Health Services

Service Description

A Level 6 service provides services at a level 5 plus it acts as a referral service for some specialised services that are linked to the specialist services provided at the facility.

The service has the capacity and capability to provide care for patients who have the most complex care needs.

Allied health operate in teams, including specialised level 4 allied health professionals aligned with clinical specialist services.

Service requirements

As for level 5 plus:

- Participates in research, clinical trials and clinical reviews
- Specialised interdisciplinary inpatient team services
- Provide Statewide or interstate referral role
- Provision of specialised clinical support and education to other Statewide services and sites
- Provide specialised outpatient services on a Statewide level e.g. cochlear implant services.

Workforce requirements

- A full range of specialist allied health positions which reflect the range of specialist services provided (e.g. ICU, cardiothoracic, paediatrics, neonatal services, geriatrics, neurosurgery, burns).

Support service requirements

Path	Phar	Rad
3	3 (pending prescription rights for podiatry)	4

Critical Care Unit (CCD), NWRH

It is important that people understand the Critical Care Unit located at NWRH is a Level 1 Unit as defined by the College of Intensive Care Medicine of Australian and New Zealand (CICM).

The unit does not meet the threshold to be a CICM Level 2 Unit (or Level 4 Unit as defined within the draft role delineation framework paper) as it has insufficient case load to meet the required CICM clinical threshold of more than 200 ventilated patients per annum.

A level 1 Unit is appropriate to support the provision of general medical and surgical care, to manage trauma, to manage patients awaiting retrieval to higher care service, to lead and manage medical emergency

teams, and code blue responses to the NWRH and North West Private Hospital (NWPH) as per current contractual arrangements.

Ear, Nose and Throat, NWRH

Clarity is required for Levels 4, 5 and 6, as the relationship between Ear, Nose and Throat (ENT) and plastic surgery is ambiguous.

THO-North West asks this relationship be better defined through the use of the words; 'on-site' plastic surgeon or 'access to' a plastic surgeon and this could be further defined to include specific procedures such as head and neck reconstruction surgery.

For more detailed information refer **Appendix A**.

Infectious Disease

Clarity is required for Levels 4 Workforce requirements to the position of sexual health RN. THO-North West asks that the requirement be better defined through the use of the word 'access' to a sexual health RN rather than 'appointed'.

It should also be noted in regards to north west infectious disease services. MCH, NWRH and Primary Health Services share resources across the north west region.

Mersey Community Hospital

The Mersey Community Hospital (MCH) is funded by the Commonwealth Government under a Heads of Agreement with the Tasmanian Government. The MCH offers general and specialist health services to the north west region. The Mersey is an integral part of THO-North West and works closely with other hospitals and primary health services to meet the needs of patients across the region.

MCH has a close working relationship with NWRH in service delivery and patient care alongside community services.

Refer **Appendix B**.

Mental Health Services

Although a role delineation model is a valid way to map out services, it does have some weaknesses in that it primarily focuses on the linkages between traditional hospital services (medical and surgical) and their support services. Mental Health Services (MHS) is dependent on linkages across a number of different specialities and community service organisations to provide safe, quality care. Links with Community Sector Organisations (CSOs) and families are an integral component of mental health service delivery.

The model does not capture the key interfaces with other services that are required to provide a mental health service for example:

- Comorbidities are common amongst mental health patients and therefore patients need access to a range of general hospital services for example medicine and gerontology.

- Alcohol and drug abuse is common amongst mental health services and is a common factor in patients that present at ED with suicidal ideation. Inpatient detoxification is required at general hospitals.
- HDU / ICU (general hospital) is required for Level 5 mental health services primarily for patients that overdose and for clients with comorbidities that deteriorate.
- Both CAHMS (Child and Adolescent Mental Health Services) and OPMHS (Older People Mental Health Services) need access to respective specialities in General Medicine – geriatricians and paediatricians – at both community and inpatient levels.

It is unclear in the role delineation model whether the ICU / HDU in Level 5 and 6 refer to a psychiatric intensive care unit (PICU) or a general intensive care unit (ICU). The presumption is the former.

The PICU / HCU model in mental health inpatient services needs to be reviewed in Tasmania as part of the delineation process. Currently both THO-North West and THO-North have HCU's that are predominantly functioning as an ICU but without the funding to do so. They are not dedicated beds but based on a swing bed procedure, which does not recognise different staffing requirements. Escorting a very disturbed patient to Hobart is difficult and this is supported by the low number of patients transported to Hobart's PICU. The options considered should be ICU capacity in each mental health unit or two PICUs – one in the north and one in the south - with the north west having capacity to stabilise a client prior to transfer. In the latter scenario, an investment would be needed to increase the capacity of the north west to provide assertive outreach to manage people in community setting as much as possible and to assist with transport to Launceston.

An ICU in mental health inpatient services does not require different expertise to that in a mental health inpatient unit. The key differences are the ratio of staffing to patient numbers and the robustness of the facility. It is therefore inappropriate to determine the location of PICUs based on the same logic as ICUs. An ICU requires a specialist in intensive care and a PICU requires psychiatrists (and other staff) who manage acute inpatient care.

There is no / little focus on subacute services. These can be provided within community setting for example house or inpatient settings. This needs oversight from specialist mental health services but can be run 24 hours day by the CSO sector. This can therefore form part of community or inpatient role delineation.

There is no mention of Forensic Services.

Both Level 5 and Level 6 mental health inpatient services require access to MRI and CT scan facilities. Radiology needs to be upgraded to Level 5 in both levels.

All Level 5 and 6 hospitals require consultation liaison services. It is well recognised that mental health is a significant factor for patients, particularly in those who present repeatedly with unexplained medical symptoms and people with chronic illness.

It is recognised that the regionalisation of some services and / or provision of sub-specialities through a hub and spoke model is needed due to the size of Tasmania for example eating disorders. However mechanisms need to be put in place to ensure that all communities have equitable access to these services. Statewide services need to be held accountable for ensuring people in close proximity are not unfairly advantaged due to geographical proximity.

Service Duplication

- It would be more cost-effective to divert money spent on psychiatrists through TasOutreach to public mental health services to increase the critical mass / sustainability of local services. This would also enhance the continuity of care for the community.
- The discussion to date in the Mental Health Rethink Project has raised the issue of case management and what components of this are better left to the CSO workforce with clinical staff focusing on therapy / treatment.

Gaps

- The lack of integration between Alcohol and Drug Services and Mental Health Services in the State. Co-location and integration of these services will significantly enhance the management of people who present with both mental health and alcohol and drug issues.
- Lack of dedicated acute mental health inpatient facilities for people under 18 and over 65 years of age in Tasmania. The options include a dedicated facility for each age group Statewide or inpatient facilities that are designed to cater for different age groups. This can be achieved by the development of inpatient units that are able to segregate different age groups, although managed as one facility. The latter option would ensure access to inpatient services is available. The majority of expertise is currently in each area (staff including psychiatrists working in OPMHS and CAHMS).
- The delineation of services for older people and CAHMS has not been considered. It is recognised that the model is broader so may not be appropriate at this stage. There is considerable work being undertaken in Tasmania in relation to youth specific services.

How to reduce attendance at Emergency Departments

- A more assertive role of Alcohol and Drug Services with people who present at emergency departments more than once in a year due to intoxication.
- Increased capacity of mental health services to provide urgent specialist clinics in the primary care setting. It is not uncommon for general practitioners to refer patients to the ED for mental health reasons primarily due to their reluctance to use the mental health helpline line. It is unrealistic to base psychiatrists in each GP practice, however, clinics for urgent / semi-urgent assessments in one or two large practices or acute centres is feasible.
- Upskill nurses in primary care to be able to screen and assess for common mental health / alcohol and drug conditions such as depression and addiction.

Building sustainable workforce models

- The role delineation model focuses on clinical service delivery. It could be enhanced by clearly outlining the responsibilities of senior clinicians in Level 6 facilities to upskill / supervise / enhance clinical quality of services provided by specialists in Level 3 / 4 / 5 facilities and General Practitioners. The service framework that is proposed for the planning and purchasing of services may also serve as the framework for enhancing the skill base and clinical safety of services across the spectrum. Telehealth could be used more extensively for both upskilling and joint management of patients.
- The current performance management framework in Tasmania needs to be reviewed as a component of the move to one health system. The current system is a deterrent to the cost-effective management of the workforce.

North West Regional Hospital

The North West Regional Hospital (NWRH) at Burnie is an acute secondary hospital offering medical, surgical, paediatric and allied health services through inpatient and outpatient care. The hospital is the receiving centre for North West trauma patients and has a well-equipped ED supported by a critical care unit / high dependency unit and a 24 / 7 operating theatre. NWRH is a secondary level service and transfer of patients to tertiary hospitals in Launceston, Hobart and Melbourne for some injuries and illnesses does occur.

NWRH has a close working relationship with MCH in service delivery and patient care alongside community services.

Refer **Appendix C**.

Green Paper - Other Service Considerations A - Z

Ambulance Tasmania

Integration with Tasmanian Health Organisations / Tasmanian Health Service

Ambulance Tasmania is not explicitly mentioned in the papers and hence it is unclear, where they will sit. Considering the role delineation framework and anticipated increase in travel, the THO deems it important that Ambulance Tasmania become part of the Tasmanian Health Service (THS) to ensure that their services are well integrated.

The current non-emergency patient transport contract significantly disadvantages the north west as St John Ambulance has minimal availability, which forces both the NWRH and MCH to access and utilise private options, which are more costly and labour intensive.

Clinical Advisory Groups Submission Papers and THO-North West Position

Integration with Tasmanian Health Organisations / Tasmanian Health Service

THO-North West ***supports*** the Government's plan to develop and strengthen government Clinical Advisory Group (CAG) mechanisms to support consultation with clinicians. The THO simply asks that the Minister advise how the CAG will integrate with other health mechanisms including HCT and the Tasmanian Health Service (THS) from 1 July 2015.

To ensure the purpose of CAG(s) aligns with the State performance measures, the THO asks the CAGs be integrated seamlessly with the THS accountability and performance management frameworks in an advisory capacity only. This will avoid any uncertainty in relation to the roles of the THS CEO and Secretary of the DHHS.

CAG	Convenor	THO-North West position
Allergy and Immunology	Dr Malcolm Turner	Submission paper not received to view.
Child and Adolescent Mental health	Dr Fiona Wagg	Submission paper not received to view.
Cancer	Dr Rosie Harrup	THO-North West has viewed and supports in principle this CAG's submission paper
Cardiology	Dr Paul MacIntyre	Submission paper not received to view.
Emergency Medicine	Dr Marielle Ruigrok	Submission paper not received to view.
Endocrinology	Dr John Burgess	Submission paper not received to view.
Intensive Care	Dr Andrew Turner	Submission paper not received to view.
Musculoskeletal	Dr Hilton Francis	Submission paper not received to view.
Neurology and Stroke	Dr Michael Dreyer	THO-North West has viewed the Stroke component of the CAG's response and supports in principle the

		Stroke Section of this CAG's submission paper
Partners in Palliative Care Reference Group	Dr Michael Ashby	THO-North West has viewed and supports in principle this CAG's submission paper
Respiratory and Sleep Medicine	Dr Nick Harkness	Submission paper not received to view.
Tasmanian Statewide Surgical Services Committee	Mr Brian Kirkby	THO-North West has viewed and supports in principle this CAG's submission paper
Trauma	Dr Sandy Zalstein	Submission paper not received to view.
Women's, Adolescent's and Children's Services	Dr Tony De Paoli	THO-North West has viewed the Gynaecology Service component of the CAG's response and supports in principle the Gynaecology Service section of this CAG's submission paper.

Consumer Engagement Reference Group

Ongoing community and consumer engagement

THO-North West has an active Consumer Engagement Reference Group (CERG) that operates on a person-centred care principle. Attendance at the monthly CERG meetings is excellent, and members regularly provide positive feedback about their involvement in the group. Members are confident to provide honest input about their own and other community member experiences.

Organisational and service delivery issues for THO-North West are regularly presented to the CERG for discussion and feedback. Members also receive information and education about current and proposed services, and are asked to consult with their community and provide feedback.

During 2013-14, CERG reviewed 67 patient focussed documents, including brochures, fact sheets, signs, and policy documents. The group has also been integral in the development of questions for the THO-North West Consumer Experience Survey. This survey is intended to measure the experience people have when they use our services.

CERG has regular discussions about a range of issues affecting patient care within THO-North West including the newly introduced national accreditation standards and the new work health and safety laws. Representatives from CERG participated in the accreditation for THO-North West Acute (NWRH and MCH) and Primary Care Services.

CERG members have created documents relating to their governance; ie "Our Strategic Direction – where to from here?" and the "Consumer & Community Engagement Strategy". Several meetings were held with members to develop the document and include principles, goals and key actions relevant to the group.

If the local CERG membership were to be disbanded and replaced with a Statewide forum then the local issues and representation at a local level would be lost.

Corporate and Support Services

Green Paper silent on Corporate and Support Services

Corporate and Support Services are not mentioned in the Green Paper. These services encompass clinic clerks, ward clerks, ED clerks, medical records, Health Information Management Systems (HIMS), eHealth, Information Technology (IT), Finance, Human Resources (HR) and operational staff. It has to be acknowledged that all services provided within the Tasmanian Health Organisations provide a service which improves patient care - either directly or indirectly - by providing support to clinicians.

The reality is that core clinical services cannot be delivered without appropriately resourced corporate and support services.

Emergency Management

Integration with the Tasmanian Health Service

DHHS and THOs are key stakeholders in the Tasmanian Emergency Management Sector and hold a number of responsibilities under the Tasmanian Emergency Management Plan (TEMP).

As an integral component of Tasmanian emergency management arrangements, THOs are required to continually review, develop and validate their emergency management arrangements and operational capabilities. To enable this process, emergency management must be acknowledged at all levels across the health and human services system as a core business activity. It is therefore imperative as part of the THOs transition to the THS that consideration be given to maintaining these activities going forward.

Presently, THO emergency management governance frameworks are based on a low cost, integrated model that enables coordination, accountability and a system-wide emergency management effect. With the exception of salaries, there is no specific funding line for emergency management initiatives across the THO and as such the risks associated with inadequate consideration during the THS transition and maintaining management arrangements are high.

General Practice Super-Clinic Contracts

Recommendation to review GP Super-Clinic Contracts

THO-North West would like to see the Commonwealth-State contracts reviewed and if necessary amended to ensure delivery of GP services includes after-hours GP capability to reduce low-acuity presentations to State emergency departments.

Health Promotion

Social determinants and health literacy

For Tasmanians to improve health and ultimately reduce reliance on hospital services and EDs, Tasmania needs to address a number of issues including social determinants of health and health literacy.

If Tasmania desires an effective and responsive health system to promote wellness, limit the long term impact of complex and chronic conditions, keep people out of hospital, and ultimately, improve the quality of life in Tasmania, it should look to embed the Working in Health Promoting Ways (WiHPWs) framework into clinical practice.

Proposed recommendations of activity include:

- Develop and or maintain a Statewide Social Determinants of Health Committee
- Utilise the Working in Health Promoting Ways Framework as a way forward
- Minimise the impact of poor health literacy
- Improve the management of people with complex / chronic disease
- Develop, maintain and regularly update a Statewide repository of programs and activities
- Support access to programs and activities which improve and maintain health

For more information refer **Appendix D**.

Library Services

Increase collaboration

Library Services already collaborate effectively across the State to deliver information and support health professionals. The librarian works flexibly to deliver library and information needs training to staff directly to their workplace across THO-North West. Being positioned close to educators in NWRH and MCH ensures that services can continue to be offered directly to staff and to medical students via our strong partnership with the Rural Clinical School, UTAS, Burnie.

There is an opportunity to improve collaboration between library staff and the clinical and nurse educators to better support the needs of education and training programs; e.g. Timely consultation and provision of tailored information to enhance specific training programs.

For more information refer **Appendix E**.

Maternity Service Contract

Recommendation to consider purchasing the NWPH Maternity Service Contract

Public maternity services were outsourced to the private sector in the early 1990s, partly in response to the public sector structural reforms arising from National Competition Policy.

MCH maternity services were returned to public sector management through the MCH Commonwealth Heads of Agreement in 2008. However, for the past twenty (20) years, NWRH maternity services continue to be outsourced to North West Private Hospital (NWPH) through an ever-green contract.

If Government is to transform maternity services across the north west and or the State, the scope and practice of the NWPH contract for service, would need to be realigned.

Mersey Community Hospital Commonwealth Heads of Agreement

Recommendation to amend MCH Commonwealth Heads of Agreement

THO-North West has managed and operated MCH since 27 August 2008. The current funding model requires Tasmania to use the hospital only for Core Clinical Activities associated medical and other purposes including consulting suites, clinical training, health research and education, health administration and other uses of a medical nature. Services can only be provided to those within MCH's catchment area.

Although the health care environment has and is becoming increasing complex, the MCH funding model has changed little over time. To adhere to improved models of care, standards of practice and credentialing requirements the current funding model is no longer fit for purpose.

THO-North West would like to amend the 'out-dated' funding model to improve the health and wellbeing of those people living within MCH's catchment. And in consideration of the Heads of Agreement original intent, THO-North West would ask Government to amend the existing funding model to enable the delivery of 'agreed' core clinical activities to MCH's catchment at NWRH. Note: funding would continue to be ring-fenced for MCH's catchment area only.

An amendment to the funding model would not only enable MCH's domicile population to access health treatment sooner, it would also enable THO-North West to build upon its two hospital-one campus model. This includes the continued strengthening and enhancing of MCH services.

THO-North West recommends the Commonwealth and State Ministers for Health support an amendment of MCH's funding model to enable the delivery of 'agreed' core clinical activities at NWRH for MCH's catchment area (domicile population) only.

Patient Travel Assistance Scheme (PTAS)

Medical services available locally

Most general practitioners and medical specialists are aware of the Patient Travel Assistance Scheme (PTAS) which provides reimbursement of travel and accommodation entitlements for patients who are required to travel to access a medical service that is not available locally.

THO-North West has noticed an increase in the number of patients being referred interstate for medical services that are available locally (within Tasmania) including neurosurgery and pain management. A significant number of these referrals have been initiated by visiting interstate specialists, consulting within the private sector such as general practice clinics.

The above presents a number of risks including:

- Declining a patient's retrospective claim for reimbursement of interstate air travel, taxi fares and accommodation meaning the potential for direct financial loss to the patient
- Medical practitioner and conflict of interest through the referring process and or payment system.

THO-North West asks that this be investigated further.

Impact of Draft Tasmanian Role Delineation Framework model

There are about 113 000 people living in Tasmania's north west. THO-North West processes about 10 000 claims from patients each year, of these about 1 000 claims are for King Island based patients who travel to THO-North West facilities for care and treatment. This means, on average each year 11.3 per cent of the north west population will travel at least 100km to access publically funded health care in Tasmania at an estimated cost of $1 540 000.

Depending on what specialist medical services are available and or retained in the north west, the implementation of the *Tasmanian Role Delineation Framework* may lead to an increase in travel for local residents, in order to access a medical service that was previously available locally. This would also impact

on the Patient Travel Assistance Scheme (PTAS), with the likelihood of increased budgetary expenditure on travel and accommodation entitlements.

Other transport options

Public transport and the lack thereof, is a major concern to those living in Tasmania's north west. It is therefore essential the State provides an efficient and accessible (both geographically and in terms of cost) patient transport system, particularly as role delineation takes effect, to take the patients to the service.

As a minimum, it is recommended a review of current transport options be undertaken to identify the gaps as there may be a need to invest and increase the capacity of patient transport services to assist and improve patient / client access to key health facilities such as the NWRH, MCH, LGH and RHH.

Stroke Services

Potential service opportunities

Tasmania's population is aging and the high level of lifestyle related co-morbidities means that demand for stroke services is increasing.

Presently, the stroke service is not delivered on a Statewide basis and services in the north west are delivered through a medical service model of acute stroke management at NWRH and MCH with acute rehabilitation services at NWRH. There is no designated acute stroke unit for the north west and high acuity acute stroke presentations are managed in either the HDU at MCH or the CCD at NWRH.

Both hospitals have an admission rate of about 150 patients each year and MCH is currently trialling an acute stroke management pathway that commences in the ED. This has been developed with a multi-disciplinary working party and in consultation with the Tasmanian Branch of the National Stroke Foundation.

There may be an opportunity to strengthen the service through consolidation and linking state stroke services which consider locating the services geographically located where people with stroke are managed and have staff organised in a coordinated interdisciplinary team.

Staff should be knowledgeable and enthusiastic about the management of stroke and be able to provide ongoing education about stroke for staff, people with stroke and caregivers. Written protocols for the assessment and management of common problems related to stroke should also be available and the implementation of a Statewide stroke assessment tool and acute stroke management pathway would be facilitated in this model.

Supplement No 1 - Sustainability and the Tasmanian Health System

THO-North West supports the Supplement No 1 recommendation including the need to include new technologies and treatments for example increased utilisation of teleheatlh services by front line staff.

Supplement No 2 - Tasmania's Health Workforce

DHHS Strategic Framework for Health Workforce 2013-2018

Significant challenges face the health sector and threaten its clinical and financial viability. Tasmania is competing for a scarce workforce and our population is growing and aging, and new models of care are needed.

THO-North West acknowledges the earlier work of DHHS and the development of the Strategic Framework for Health Workforce 2013-2018 which considered capability, capacity, quality, support and sustainability of the Tasmania's health workforce going forward.

Therefore, THO-North West would ask Government to endorse, resource and recommence implementation of the Strategic Framework for Health Workforce 2013-2018 as it is noted significant consultation with stakeholders has already occurred with excessive centralisation of decision making which also address leadership, management and achieve future sustainability and is not dependent upon but rather will support the Government's ability to introduce its role delineation framework.

As part of this, Government will need to ensure it addresses the budget shortfalls relating to the ongoing learning, development and research needs of its professional workforce. This is essential in order to maintain the workforce meeting their full scope of practice, decision making and credentialing, to ensure the ongoing delivery of safe, high quality and cost effective services. In essence this will align and meet the priorities and requirements of the: individual, professional organisation and the agency's health workforce.

Performance management improvements

The current performance management framework in Tasmania needs review as a component of the move to one health system. The current system is a deterrent to the cost-effective management of the workforce and a number of barriers exist that impede addressing inappropriate behaviour and performance management in the health service generally.

Recruitment and retention remains a significant issue for regional areas due to a number of reasons which relate to things such as the lack of patient acuity, career progression, inability to maintain skills due to low volumes, lower salaries, professional isolation, attractive schooling options for families and other perceived attraction issues. Whilst the outcome of the role delineation work may result in a more refined model of what and where particular services are offered, there will continue to remain a need to provide a range of services in regional areas which are dependent on suitably skilled and qualified staff that are proving to be increasingly harder to recruit and retain.

Other challenges are what the THO would classify as "cannibalism" where the attraction of the larger hospitals like the LGH and RHH are such that the best candidates are lured to these centres (and at times poached) which results in further challenges in attracting and retaining the best staff. The move to a single THS has real potential to address this issue through a planned approach to workforce management by considering the challenges mentioned in the paragraph above and by exploring options such as a rotational policy where medical staff have the ability to rotate through both the major hospitals as well as spending

time in the regional areas. There is an opportunity for parochialism to be put aside so that staff are recruited to where they are needed, regardless of the location. Approaches like this will not only support our regional areas but also develop and build the capability of our workforce with the ultimate aim of improving patient outcomes and potentially assisting with our workforce challenges.

Our regional areas suffer from quite an image problem when it comes to attracting and retaining medical staff. This is evidenced by the large volume of locums that are required to just ensure services can be staffed. This model is not sustainable, thus serious consideration must be given to a robust workforce management plan and ensuring that through the role delineation work, the services offered by regional areas are not diluted to such a degree that they become so unattractive that the staff who will work there are staff the THO shouldn't be considering to recruit.

The issue of barriers in addressing inappropriate behaviours and performance management is one that relates to not only the health service but the whole of the State service, and one that must be addressed. Clearly there are directions and policies which support the management of these matters; however the problem is that HR staff and managers continue to toil away in an environment that is overly risk averse, policy and procedurally bloated and excessively time consuming. All these factors combined result in many cases of managers not actively pursuing these matters due to the time involved and importantly the belief that at best even in serious cases the sanctions don't fit the offence (we are too lenient).

Our employment is probably the most protected work environment in existence and the standing joke is that the only way you leave the State service is when you kill someone, resign or die. The right of employees to natural justice and procedural fairness is paramount, but the State has taken this to the extreme and a comprehensive overhaul of the way in which the State works in this area is required so that it strikes a balance between timely, efficient and meaningful performance management and employees rights.

Growing the health workforce

The education sector and its interface with the health sector is crucial to preparing how health service can and will be delivered in the future. There is huge potential for education institutions like UTAS to work more closely with THOs (and THS) to address workforce development plans, and signal areas for future workforce development.

The role of THOs as educators needs to be strengthened with teaching part of being a professional and this should also be reflected in job descriptions and/or contracts.

The education sector needs to ensure it is responsive to changes in health workforce requirements and that mechanisms are put in place to ensure the relevance of courses and diversity of students entering programmes for the health workforce.

THO-North West would support the development of an action plan to facilitate the evolution and further development of health workforce education, integration and competence.

Ensuring a high quality, safe health workforce

THO-North West notes the Supplement No 2 is silent on the matter relating to the safety of the health workforce including mandated requirements such as vaccinations, occupational exposures, needle stick injuries, blood and body fluid exposures and health screening including TB.

We would recommend consideration of these requirements be included in any workforce strategy developed in the future and appropriate resources identified.

Recruitment of Junior and Resident Medical Workforce

Intern recruitment

In 2015, a recruitment campaign process was combined with THO-North, with interviews and interview scores shared between THO-North and THO-North West. Candidates applied to each THO separately. SODs were updated to reflect the rural working environment, and candidates were required to answer selection criteria. Candidate total scores were based on answers to selection criteria, referee scores and performance at interview, to make a score out of 100.

- The whole process worked better than previous years
- It was more efficient
- Attracted applicants that had the desire to work in rural / regional practice
- Attracted applicants who suited our environment
- Allowed a meritorious appointment process
- Updated SOD suited THO-North West requirements
- Less issues with people declining positions / moving hospitals

From a THO-North West point of view, the 2015 campaign was the *best managed* program of recent years, in regards to intern recruitment. The THO was able to review candidates, interview and appoint people who wanted to work in the north west.

Possible improvements to consider if same model for 2016

It was noted that students at UTAS applying in other regions like Hobart were provided little if any recruitment information and in some cases needed to be interviewed twice for a placement in Tasmania. The THO is also advised some students from the Rural Clinical School wished to work in Tasmania but were unable to obtain a placement.

If the recruitment model remains unchanged, then communication between hospitals should be improved to ensure offers are not made to candidates who have already accepted an offer from another hospital.

If it is decided to be a Statewide approach

- THO-North West would not wish to accept poor / sub-standard candidates, nor candidates that do not wish to be here
- THO-North West will need to be involved in selection process
- Each site to be given a choice of candidates
- THO-North West require meritorious candidates, who have met employability criteria
- Ideally external bodies are not to advise who the THO do / do not employ

No matter the recruitment approach, to ensure graduates doctors move into communities and specialities that need them most, the THO asks that Government consider payment to reward junior staff who agree to work in hard-to-staff communities and/or specialities, in Tasmania. For example and similar to established schemes like the Australian Bonded Medical Places (BMP) Scheme and the New Zealand Voluntary Bonding Scheme, payment could be in the form of an annual payment to repay a student's loan or as a top-up income.

Recruitment of Resident Medical Officers

Presently, THO-North West may make an offer to an RMO but at the same time THO-North may also make an offer to the same RMO. The RMO may then cherry pick the organisation's pending offer and conditions. Better communication, planning and clarity on criteria and an understanding to prevent RMO poaching is desired due to recruitment time and costs. The potential to consider payment to reward resident medical staff who agree to work in hard-to staff communities and/or specialities is also an option.

Possible improvements to consider for Registrars

Suggest a Statewide training program for all disciplines (same as TATP Anaesthetic Training Program) or rotational appointments for trainee and non-accredited positions. This will attract better candidates, and allow rotation through tertiary / rural placements.

Action of the above would greatly improve the management and rotation of registrars across the State.

Potential to reward hard-to-staff communities and or specialities

Similar to the Australian Bonded Medical Places (BMP) Scheme and the New Zealand Voluntary Bonding Scheme, of which both are intended to attract qualified clinical staff to areas experiencing staffing shortages. The Tasmanian Government could consider a similar payment to reward targeted staff like doctors, midwives, nursing and allied health staff, who agree to work in hard-to-staff Tasmanian communities and/or specialities.

Potential workforce change to Health Information Management, eHealth & ICT Services

It is proposed that all services in relation to health information management and eHealth are moved into the new Tasmanian Health Service. This will create a centre of excellence for Health Information Management Services.

For more information refer to **Appendix F**.

Potential workforce change to Palliative Medicine

THO supports in principle the Partners in Palliative Care Reference CAG submission papers.

For more information refer to **Appendix G**.

Recruitment of Non-Clinical Support Services

The Green Paper does not acknowledge the non-clinical support services required to support the organisation i.e. administrative, health information, information technology, operational staff (cleaners, ward persons, kitchen, and stores). How will these staff be attracted to the organisation and kept?

Some of the non-clinical staff are difficult to recruit, such as clinical coders. Non-clinical staff provide important support to the clinicians, so front line staff have the tools, time and information available to provide high quality and timely clinical care. It is important that non-clinical staff are viewed as a valuable resource to support front line staff.

Supplement No 3 - Building a Stronger Community Care System

THO-North West would be a willing partner to develop local integration care centres which could also include the integration of those Community Health Centres located in the north west

Community Hospital Interface Program (CHIP) has been successful in Brisbane hospitals also i.e. Princess Alexandra Hospital, Logan Hospital, Queen Elizabeth II Jubilee Hospital. These nurses are based in wards and ED and commencing working with community providers while the patient is still in hospital to ensure smooth transition to home and services are in place, similar to CARS.

Primary Health Services – Community Nursing Services

THO-North West has a number of sites where health services are provided across a single agency.

As a concentrated effort to identify the clinical service and workforce requirements for THO-North West, having regard to the total needs of both public and private sectors, there is demand for a planning process, or something more functional in terms of simplicity.

The potential for Community Nursing Services to alleviate the pressure of ED readmissions for ongoing care has been noted many times. For example, wound care and intravenous antibiotic care could be referred to community nursing to alleviate the re-presentation at ED.

The ongoing utilisation of enrolled nurses to practice within their scope needs to be encouraged, to enable registered nurses, as per EBC at ratio of 25% ENs to 75% RNs.

Looking at the current services for clients / patients in place at this moment, and examining the need / necessity to implement new services when possibly extra resources could increase the service provision potential of current services.

This would reduce the confusion for clients / patients / carers / and other health professionals regarding 'who was doing what' for the client. It would potentially reduce the number of people / staff / services visiting the client's home.

There are travel concerns for clients / patients and their carers if hospitals become "specialist" for various conditions / treatments. For north west clients the concern of travelling to Hobart for example, for both themselves and their carers places extra pressure at a time of being unwell. The impact then of carers being required to stay "out of area" while the client is in hospital also adds to a financial and emotional concern.

Improving / increasing the video conferencing capabilities between specialists and clients would assist in reducing the need for travel to appointments or reviews. This is occurring at times but could be increased in use.

Aging workforce of nurses (with potential retirement in the near future) could impact on availability of nursing staff in all nursing areas in the future and although this is being discussed continually both nationally and internationally, a solution to address the issue / concern remains unclear.

Examination of the role of community day care centres to look for opportunities to provide additional low level care may remove improve the delivery of care for some patients / clients.

Primary Health Services - Palliative Care Services

Palliative care is confronting the similar challenges which exist at the role delineation or local level and are aware that this is not confined to Tasmania's north west. The priorities that have been identified include adequate and appropriate resources (e.g. health professionals, carers, equipment and education) are required to provide sustainable care to community palliative clients and to support their families / carers.

Many people with a life limiting illness may choose to remain at home for end of life care, and in the majority of cases they are supported by enthusiastic and loving families and carers. Regardless of the amount of support made available to clients / families and carers, the constant pressure of providing ongoing care to a loved one often results in family / carer fatigue and "burnout". This crisis may necessitate the client being admitted to hospital, the exact opposite situation that was initially chosen by the client and family / carer. The availability of hospice care would prevent these situations from occurring, and would provide an environment where families / carers are able to spend quality time with a loved one, without feeling the pressure / burden of providing 24 hour care / support.

Primary Health Services - Infection Control

Infection control in the community and primary health is similar to those faced in the acute sector.

The level 4 Service and Workforce requirements met at each rural site include:

- General inpatient beds for care of patients with infectious diseases
    - Isolation rooms with internal wash basins and toilets – all sites
    - Staff wash basins immediately outside the room – all sites.

There are no negative pressure rooms available at the rural sites, however, patients are transported to either of the two acute hospitals in the region if negative pressure rooms are required.

- Delivery and administration of home-based therapies to patients requiring intravenous antibiotic therapy – all rural sites and Community Health including BACH
- Formal access to specialist infectious disease and sexual health physicians within the network – formal contract with the RHH for the provision of ID services for the North West
    - Access to local Sexual Health Service by telephone and face to face as required
- Onsite physician practicing in general medicine – available for consultation within the THO-North West
- Appointed Sexual Health RN – access to community based Sexual Health RN on request
- Youth Health Service and appointed Youth Health Nurse

The level 5 Service and Workforce requirements partially met include:

- There is also a dedicated Primary Health Infection Control CNC available to provide advice to staff working in the rural sites / community health / community mental health services as required.
- Has a teaching and research role – IPC CNCs have a teaching role (medical and nursing staff, allied health, community services, aged care facilities and students)
    - Regular surveillance activities are conducted at rural sites

- Appointed Infectious Diseases physician – the THO does not have an appointed ID physician but it does have a formal contract with RHH for the provision of ID services for the north west.
    - There are ID clinics conducted at the NWRH at regular intervals throughout the year
- Appointed sexual health physician – the THO does not have an appointed Sexual Health Physician but it does have access to sexual health personnel by telephone, video link and face to face on request
- Onsite clinical microbiologist – whilst the THO does not have an appointed clinical microbiologist our contracted lab has a contract with a clinical microbiologist. The clinical microbiologist is based in Hobart but is available by telephone and is onsite at regular intervals during the year. This clinical microbiologist has been included in the membership of THO-North West Infection Prevention & Control Committee and attends meeting face to face when onsite. The clinical microbiologist also has membership on the AMS committee.
- Medical officers are available on-site 24 hours.
- RNs with specialist infectious diseases expertise – CNCs are employed at both of the acute sites and in PHSs. PHS CNC is off site due to the location of PHS sites but is available for consultation via phone / email and makes very regular site visits to all PHS within the THO-North West. The CNC IPC is an authorised Nurse Immuniser able to assist the Occupational Health Nurse with vaccinations at site visits.
- All the CNC's have appropriate post graduate qualifications.

Primary Health Services - Stanford Chronic Disease Self Management Program

The Green Paper outlines the process to be used for determining where and how services are provided; balancing safety with access, efficiency, suitability and equity and the THO would ask that Government consider including and or applying the Standford Chronic Disease Self Management model.

For more information refer **Appendix H**.

Primary Health Services –Youth Health and Health Promotion by Social Media

THO-North West supports in principle, the approach taken by Youth Health to access and utilise modern communication tools like Facebook to engage with Youth. Funding for these new technologies will need to consider not only the impact on the way the service is delivered into the future but should also include back-office workforce requirements.

For more information refer to **Appendix I**.

Integration of primary and hospital level care

In May 2014, the Commonwealth Government budget introduced changes to the way Primary Care Services will be managed, replacing Medicare Locals with Primary Health Networks (PHNs). PHNs are to be responsible for improving the health of their communities, working with hospitals (both public and private), GPs, specialists and other health care provides. They also play the role of planners, integrators and purchasers of health services and no longer deliver services directly to the community, unless there is demonstrated market failure.

There must be better integration between the THS and the new PHNs than has been experienced with the last two years of three THOs and Tasmania Medicare Local as a number of duplication between the Tasmanian public health system and the Commonwealth funded primary care system remain.

THO-North West would ***support*** the reconfiguration and or integration of TML / PHN services with both DHHS (as the funder) and THS (as the provider) as it would enhance the continuum-of-care – from birth to death - for all Tasmanian's.

As part of this, the Tasmanian Health Assistance Package demonstrates how much money can be wasted when the Commonwealth throw money at a problem but do not adequately prioritise its use or have adequate systems, structures and measures in place to ensure that it is being spent on initiatives that will yield sustainable change. In future, THO-North West would ask Government to ensure that appropriate systems and measure are in place to enable project success.

Supplement No 4 - Emergency Care

Appendix J should be read in consideration of the Emergency Medicine CAG submission papers and the broader comments relating to service provision in the north west.

Supplement No 5 – Elective Surgery

THO-North West supports the development and implementation of a Statewide Elective Surgery Waiting List (ESWL) which does not unfairly disadvantage those living in Tasmania's more remote areas such as the West Coast and King Island.

THO-North West asks that the referral process be reviewed to minimise elective surgery waiting list decision making, while ensuring the ability to jump the elective surgery waiting list by both public and private patients - is minimised. As part of this, the review should look to fast-track integration of the TML led Health Pathway project with the THOs and or THS to smooth the flow of referral information that enables clinicians to care for patients more effectively.

Specific to the Green Paper supplement Statement that patients are not being treated in turn and subsequent variation in waiting times within the categories is inaccurate and may be misleading to submitters, it does not consider:

- **Not ready for care patients:** Patients who are managed as not ready for care are not counting waiting days (for a variety of reasons) and then when they have their surgery they are having it at less waiting days (as per ready for care status), but in actual fact have been waiting on the list for longer days.
- **Overnight admissions:** Due to the actual acute bed restrictions this has an impact on the number of overnight admissions that the THO can admit patients to, therefore the theatre sessions are often filled up with minor cases to support theatre utilisation and also treating any one of the patients that are waiting on the elective surgery waiting list.
- **Adherence to national treatment in turn monitoring and reporting**: In relation to the reporting of the waiting list the minor and major cases treatment in turn principals and waiting list reporting to be potentially reported separately. This has been broadly discussed at the Tasmanian Statewide Surgical Services Committee (TSSSC) meetings and the working group for 'national treatment in turn monitoring and reporting'.

- **The different clinical specialities:** some clinicians do have a shorter waiting list and therefore their patients do have their operation sooner than those with longer lists – and this is also dependent on the speciality.
- **Theatre time variations:** Pending the patient's condition, some procedures are treated before other procedures due to the amount that can be best fit allocation onto a theatre list and also for clinical teaching purposes.
- **Change of patient condition:** Some patients also have a change in clinical condition and specifically requested by the clinician – but not necessary a change in category.

There are a number of clinical factors to consider and this supplement ignoring of the above.

Green Paper – Set Questions

NOTE One: The views expressed below in response to the Green Paper set questions have been collated by THO-North West on behalf of staff and it should be noted the views expressed by staff do not necessarily represent the official opinion of THO-North West.

NOTE Two: Many of the views expressed by staff are similar if not the same as those views expressed by members of public and community representatives who live Tasmania's north west.

Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?

- Yes the Tasmania health system should be able to change. It needs to be more organic and grow / evolve to meet the needs of the population and to stay up to date with clinical practices. Staying the same is not safe and does not provide the best care possible.

If it improves the quality and safety of care, do you agree we should limit the number of sites at which some services are provided?

- Yes, or if there is a cluster of patients then provide mobile surgical teams that are deployed to the nearest facilities to patient residence with capability and undertake all procedures within one or several days.

How well does the proposed framework (Tasmanian Role Delineation Framework) align with practice in your discipline?

- Role of the MCH is appropriate to local need given the current duplication of hospitals in the north west.
- Maternity services can be expanded and consolidated at the MCH given proximity to level 4 services at LGH.
- MCH Day Procedure Unit / Outpatient Department – due to the day only / specialist clinic role delineation of the MCH, the DPU and Outpatient Department requires a major renovation. Both areas have outgrown their capacity due to increase in activity and renovation is required to improve and increase the current flow of patients through the departments.
- Medical Day Unit / Oncology Department – it is essential that some level of service for cancer treatment is maintained at the MCH for the population of Devonport/Latrobe/Shearwater. This treatment is particularly exhausting along with the disease process.
- Capacity for high number of day cases performed per day.
- Ability to utilise surgical floor beds for overflow if required.
- Access to support services – pathology, medical imaging, physiotherapy.
- Expertise in medical, nursing and allied health available within hospital.

- Patient flow areas require update if greater capacity required.
- The operating theatre at the MCH seems to fit in mostly as a level 3 - 4 facility. On one occasion, it fits in only as a level 2 facility and that is for Paediatric surgery as only dental or ENT surgery is performed on low anaesthetic risk children over two years old.
- Not far removed from what we are doing now.
- The Devonport community is too large to ignore with ED services, still need 24 access for walk in care.
- Need to build bed capacity and availability at NWRH & LGH and fix access block before even trying to redesign service – this applies Statewide. Otherwise any change in service delivery is doomed to fail.
- NWRH is a regional acute secondary hospital. It provides a range of general mainstream services for a regional hospital providing acute care to a population of 113,000 in the north west that is also serviced by MCH. The current levels of services are at a majority of level four with some at a 3 and 5 as per the role delineation framework. Geographically it has the population spread out over wide distances and it is reasonable that there is a regional hospital with ability to manage acute care, and emergency treatment at a complex level in the first instance.
- There are voiced concerns that the delineation will disadvantage some clinicians in the types of patients they can treat in relation to complexity and volume particularly.
- The framework does not translate well in the areas of oncology/cancer services. Best practice is for an integrated service and the delineation breaks it up and does not support this approach.
- Our current ENT surgeon has raised issues with removal of procedures at a level five from NWRH but this is not necessarily the consensus of THO-North West.
- There is opportunity to role delineate further between MCH and NWRH with NWRH the acute hospital and MCH the sub-acute hospital. This would fit within current service level at NWRH of four and strengthening any areas to ensure safe high quality care delivery at an affordable price.

Where are the areas of service duplication in your discipline?

- Community services duplication between TML and THO services however no governance of the non-THO services is leading to issues i.e. 141% increase in requests to CES for 4 wheeled walkers from non-THO service providers; differing practice philosophies; service provision by care coordinators at TML with caseloads of 12 patients.
- A number of overlaps of eHealth, ICT and Data management are identified within **Appendix F** of this document.
- Base hospital at Ulverstone should be strongly explored to allow proximity of health care to the population base and tertiary hospital access e.g. LGH. WHO (World Health Organisation) advise that hospitals should be constructed central to larger population base has this been explored along with role delineation?
- MCH dedicated day surgery unit, however a number of procedures are performed at NWRH.
- The MCH theatre is the Centre of Excellence for Endoscopy procedures. It is envisioned that when the second Endoscopy Unit is up and running that our services will increase on the north west coast. Currently, the sole unit is in constant use all day, every day, five days a week. The waiting list is long which is why the NWRH now has dedicated lists, which was not the case previously.
- It is felt that MCH has been moving towards a service providing Out-patient care with Endoscopy, ophthalmology and Day surgery as a specialised centre of excellence.
- The only area it is felt we are duplicating service is in paediatric clinics.

- NWRH cover general paediatric clinics as they have a paediatric ward and MCH cover outreach i.e. allergies, asthma and behavioural issues.
- From the point of view of patient access, we are offering clinics appropriately. Despite the fact that we don't necessarily provide the inpatient care or surgery i.e. vascular, clinics are appropriate for patient follow-up and convenience.
- It is not seen that there are too many areas of duplication. Tasmania has started some years ago to move towards centralising some services at specific sites in the North, i.e. renal service and plastics only at LGH, not in the north west.
- Within THO-North West day procedure services are duplicated and it should be decided which facility is going to undertake for example endoscopy, ophthalmology (day cases). Small numbers of ENT and Orthopaedic (be centred at NWRH).
- Emergency Department operating 24/7 at both MCH and NWRH is not sustainable from a workforce perspective to ensure safe, quality service. Role delineation between the two hospitals would support a more sustainable workforce.
- A High Dependency Unit at both NWRH and MCH. Clinical governance over MCH is not robust and it is suggested that this unit should be reconfigured based on clinical risk.
- Cardiac Rehabilitation services are operating out of both NWRH and MCH and could be run as one program for the north west.
- Maternity services at MCH and North West Private Hospital.

Where are the gaps?

- Lack of specialised inpatient and outpatient geriatric care. The north west has fastest ageing population in the State. Consideration should be given to a geriatric evaluation and management inpatient service.
- Access to inpatient and outpatient psychology and neuropsychology services for adults and children in the north west.
- Child Development Units are currently out of scope and there would be an argument to include these to sit alongside our existing paediatric allied health services.
- Chronic disease management services are not focused on as a priority – population needs are not necessarily taken into account with service planning.
- Transport.
- Access to inpatient allied health services for acute mental health patients is minimal.
- Access to pain management services as per the tier levels in the National Pain Management Strategy.
- Access to specialise paediatric dentistry and orthodontics through the public system.
- Lack of clear pathways to certain services such as vascular services (links from Podiatry).
- Access to weight loss surgery/weight loss advice – no dietitians in the primary health service.
- HDU should be maintained as Coronary Care Unit given proximity to the LGH Cardiology Unit.
- Transport is a major issue for MCH and NWRH given current role delineation and the increased need for ambulance and NEPT. Private Ambulance use remains -pushing up expenditure due to deficit.
- GP Clinics within the north west require expansion to include both extended opening hours and bulk billing. ED presentations cannot reduce without GP access within the community setting. Minimal ability to refer presenting patients to community clinics for ongoing care.

- Community Health Nursing and Palliative Care on the north west require boosted funding to expand services provided. Currently the hospitals are required to support this deficit leading to extended length of stay and re-presentation of patients.
- Too many day surgery procedures at NWRH to fill gaps due to general surgery restrictions.
- For the Operating Theatre, an Anaesthetic Registrar on call for a 24 hour period would make this facility a level 4 for Anaesthetic Services and alleviate the work load for the on call consultant/specialist.
- The gaps are in outpatient cardiology. Will need someone who is readily available for out-patient echocardiogram, reading of Holter monitor and performing of stress ECGs.
- Hospital in the Home (HITH) or nurse led clinic to be re-instated as an area of need. HITH is associated with reductions in mortality, readmission rates and costs. Can provide postop care and follow up support for surgical and day surgery cases.
- Consider GP clinic at MCH with nurse run clinics to assist in all areas to aid in reduction of hospital admissions due to chronic illness.
- Palliative Care need increased community resources. Need for hospice beds within MCH.
- Need for case coordinator for paediatric children with autism, behavioural problems, Attention Deficit disorder.
- No care provision for when these children pass the age of 18, needs still being serviced by paediatrician.
- Transport.
- Need for PEG tube clinics. High number of patients on north west coast with feeding tubes and lack of support for education and tube changes.
- Huge gaps in orthopaedics. Not enough orthopaedic surgeons/clinics. Huge waiting lists for joint replacements. Category 2 and 3 patients will never be seen or have their joint replacement, as per existing constraints on orthopaedics, (predominately due to funding issues)
- Need to improve transport services; need better access for urgent and non-urgent Ambulance services, patients wait too long at present for transfer, detrimental to outcomes and increases mortality and morbidity.
- Need to improve dramatically public transport services between Burnie, Devonport, Launceston – to make it easier for families and importantly being able to return people to their homes after discharge – this is important for those patients that are sent to another hospital for assessment by a specialty, i.e. plastics at LGH. They are often assessed, treated and released on the same day and have no way of returning to their home, particularly if transported by Ambulance Tas
- MCH has become a centre for transfers to other State facilities and support provided to enable transfers is insufficient and no further proposals appear in the framework to improve the service, transport vehicles or staff.
- As a transferring facility within THO for complex care transport is the greatest issue for all departments within MCH.
- Drug and alcohol services need to be expanded in the north west and ideally co-located with the MHS.
- Maternity Services are contracted by THO-North West to NWPH from NWRH budget. This should really be in the public domain and without the case mix from MCH, joining it is probably not sustainable. For a sustainable obstetrics service in the north west, MCH obstetrics unit should amalgamate with NWRH in providing 1200 births for the region, which is a sustainable service. The level of services is about a level 4 with births from 34 weeks onwards and some from 32 weeks with consultation.
- Urology - General surgeons should admit for simple urology with shared responsibility that is documented on the patient medical record.

- A north west chronic pain management service is not available. Patients are managed via GP, physicians, as out patients and few access RHH services due to travel issues. The service offered by the South is not meeting demand of the north west and there are some query whether they will supply to the north west. This area will need development as a Statewide service so that the patients in the north west can access timely, appropriate local access. These patients express that they cannot travel long distances in cars to access RHH services.
- There is only one permanent intensivist and the medical workforce is 'propped up" by anaesthetic and locum intensivists. Sustainability of workforce in critical care is a critical issue.
- There is no local paediatric inpatients care in a specialised mental health service. Majority of patients are inpatients on the general paediatric ward. Some older adolescents may be admitted to Spencer Clinic. Access to a specialised unit is in Hobart, which makes family support difficult.
- Rheumatology could be via outreach for the north west, telehealth/face to face or accessed in Launceston.

Are there any services being inappropriately provided, or planned, at your facility?

- Psychogeriatric services – very sporadic service provision and not viewed as an option by acute services i.e. problems in having surgical patients with delirium properly assessed and treated.
- Some complex ENT surgery.
- GP clinics within the MCH could be introduced with a bulk billing system to refine presentation streams and access point. This system would allow for access to radiology and pathology services.
- Currently there are no services inappropriately provided or planned in our department.
- In the opinion of the operating theatre at the MCH, all procedures are performed here with expertise, equipment and appropriate qualifications. Teaching and training nurses and junior specialists are carried out with integrity to achieve high standards.
- Pre-admission reviews of some bariatric patients not deemed necessary incurring cancellations at theatre level due to co-morbidities not dealt with.
- The GPs have to come on board with this plan. They need to understand exactly which hospital and service to refer their patients to. They need to be more proactive in working with the hospital to organise and plan care for their patients. A Good example is a patient with a chronic condition needs iron infusion, they should be able to organise this from their surgery so that the patient arrives at a designated time and place to have their treatment, not just send them to ED with a letter and get the ED to organise the whole thing.
- Devonport needs better access to GP services, extending opening hours of surgeries.
- The reality of our community is that there is a large group of low social economic residents that just cannot afford to go to the GP and pay to see a doctor; therefore they use ED because the cost to them is nothing. Their pathology testing and radiological services are provided at low cost, in a very timely fashion, often within 2 hours.
- People need better access to outpatient services to keep them out of hospital. Better access to community physio, community services need to be promoted more by GPs, practice nurses are a great way of educating patients.
- Patients that are transferred to another facility for initial care need to be repatriated as soon as practical to their home area, freeing up beds for others.
- Transport – readiness and bed availability at receiving facilities cause delays in planned care.
- Services that have a single practitioner are not sustainable in the long term. Currently the ENT surgeon is oncall 24/7, which is not in accordance with safe work hours practice. In addition, some

of the surgery performed is level five which is not suitable for a level 4 ICU/Hospital delineation as not all the services that those patients require are available.

What services do you currently receive in a hospital setting that you think could be safely delivered in your community?

- Routine gynaecology procedures i.e. pap smear at GP rather than outpatients clinics.
- IV antibiotics – use Hospital in the Home model.
- Wound care.
- Some outpatient allied health services were specialist equipment is not required.
- Alternatively coordinate visits for patients who are coming to the hospital to see multiple people on the same day rather than multiple visits on different days.

How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?

- Education to GPs.
- Continuation of GPLO positions.
- Bulkbilling GP visits.
- Better case management to prevent hospital admissions.
- Appropriate triage protocols.
- Enforcement of the use of the Health Pathways.
- Introduce Community Chronic Disease Services for Cardiac, Diabetes or Respiratory conditions. Every patient who presents to ED for a cardiac, diabetes or respiratory conditions are referred to this service for education and support on self-management.
- Create community centre, central to all areas within the north west coast to provide:
    - Phone services attended by a healthcare worker.
    - Information services – general information. i.e. location of facilities, transport availability.
    - GP access to free up ED and GP surgeries.
    - Care coordinators to assist relative and patients.
- Trained ambulance personnel – ability to assess patient condition in the home. Increased frequent public transport. Education community, radio, newspaper, flyers in GP surgeries and ED.
- Communication, promotion and advertising.
- Brochures, pamphlets.
- Make the community aware of what is available because ignorance is rife. Potential customers/clients have no idea what services are available and where to go for specific treatments.
- Obtain GP co-operation.
- 24Hr GP super clinics.
- Nurse led clinics for prevention and management of chronic illnesses.
- HITH with support of designated Medical Officer.
- Increased community and palliative care nurses with funding for "night care" for palliative patients.
- Improving outreach care and access, keeping people out of hospitals. Make it easier for GPs to organise treatments for their patients, i.e. iron and blood transfusions, wound care clinics, mobility clinics. EDs are dealing with some things that should never present because it is not available

anywhere else, difficult to organise or services are working to capacity, demand outstripping supply.

- Need to improve access for parents and children. A lot of children seen in ED are seen because parents have poor coping skills in caring for minor illness with children, febrile child, child with egg on head. Immunisations are being missed. Clinics targeted at families in their local environment may assist. Even improving the health of parents, working with them about contraception and diet.
- ED – close relations with GP in the community. Allied Health promote via community services that these align when creating holistic care for patients. During this process external providers liaise with ward staff.

How do we determine which services to focus on to expand the role of primary and community care?

- Look at top 5-10 chronic disease as listed in both ABS and TML reports.
  Review social determinants of health.
- Review DRG wait times and admissions.
- Use the data that is collected by the Business Intelligence Unit for service planning. As per the Supplement 3, you are already looking at avoidable admissions but what have other States done to address these?
    - Influenza and patients who didn't have vaccinations – can population health help with promoting a vaccination program or outreach vaccination clinics at chemists?
    - Wound management - are patients presenting to the hospital instead of Community Health Nurses or GP?
    - Chronic diseases not managed well
    - Category 5 ED presentations – what did they present to hospital with?
- Metro South Health and Metro North Health in Queensland has had success with hospital avoidance programs and chronic disease initiatives.
- Survey of ED presentations.
- Work with GP surgeries to assess workload.
- Inform community to gain input from the public.
- Need to determine the more common ailments which affect each area e.g. where are the highest aged population, highest disabled population?
- Consider access to consumers and customers e.g. where is the best area/facility for customers with specific ailments.
- Transport that doesn't depend on a long list of criteria in order for consumers to access.
- Expand the role of Community Care nurses to integrate Hospital in the Home duties.
- Geographically the north west has a high incidence of cardiac complaints, cancer and birth defects and diabetes. Need to focus on disability care, outpatient cardiology and improving access to community and palliative care with increased funding for provision of these services.
- Need for 24 hr GP access clinics could be incorporated on-site at MCH with nurse practitioner support.
- Transport.
- Telehealth conferencing.
- Disability services in particular for head injuries.
- Overall in Tasmania, services will wane until it can be agreeable with centralising services and determine which areas will provide. This will be enhanced further if it can be agreed to have one

major base hospital in the north west, either hospital standing alone doesn't give capacity for advancement.

What services do not have sufficient volume or activity in Tasmania to maintain a safe, high quality service?

- Complex paediatric orthopaedic surgery or other complex paediatric surgery – should be done in Victoria.
- Neurology.
- Advanced plastic surgery.
- Vascular surgery.
- Improving outreach care and access, keeping people out of hospitals. Make it easier for GPs to organise treatments for their patients, i.e. iron and blood transfusions, wound care clinics, mobility clinics. EDs are dealing with some things that should never present because it is not available anywhere else, difficult to organise or services are working to capacity, demand outstripping supply.
- Need to improve access for parents and children. A lot of children seen in ED are seen because parents have poor coping skills in caring for minor illness with children, febrile child, child with egg on head. Immunisations are being missed. Clinics targeted at families in their local environment may assist. Even improving the health of parents, working with them about contraception and diet.
- Volume has been raised by some clinicians as an issue that is not as straight forward as it would appear. It may be considered a valid fact in some services delivery but skill sets for different procedures have a commonality and should be considered.
- The only way to have a sustainable workforce is to have enough case mix in the medical area to employ more than 4-5 consultants. Services, which are person dependent or a have a small number of doctors is not sustainable and may be operating outside AMA guidelines for safe work hours.
- The Critical Care Department (CCD) at NWRH has by the CICM definitions met on average level one unit criteria and not a level two criteria. This is on the basis that unit has never got to the threshold of having more than 200 ventilated patients pa (the criteria used to be 150) in the last 4 years or having more than two CICM credentialed specialists (except for a short period of about 15 months).
- In terms of surgery supporting ICU, if you look at the data for NWRH many of the surgical patients that go to ICU may not meet the criteria of an ICU in other hospitals. The amount of complex level 5 elective surgery in NWRH is minimal. The complexity is due to the emergency cases and any new role delineation for trauma these patients would be transferred therefore decreasing complexity. The decrease in complexity means that skills of the staff in ICU may not be maintained.

What additional areas should we be considering for interState partnerships in order to improve service within Tasmania?

- Paediatric rehab – see current process.
- Complex paediatric surgery.
- MCH currently has good interstate partnerships for paediatric cardiology and this should be maintained.
- Transport, accommodation, referral processes.
- Plastics/reconstruction - wound care guidance. Via Telehealth.

- Affiliation with interstate hospital i.e. Alfred as "sister" hospital. Could be resourced for protocols and care guidelines.
- Acute stroke unit.
- It is vital that both RHH and LGH take trauma. Both hospitals have the capacity to deal with most traumas, except neuro which is only at RHH. Centralising trauma only in Hobart would reduce professional capacity and skill in the north of the State and patients should be treated as close to home as possible.
- Highly specialised services should be reviewed to determine if Tasmania should provide the service or not.

What services, despite comparatively low volumes, should we continue or invest in, in Tasmania and what interstate support may be required to maintain them?

- I think any service currently on offer in Tasmania should not be sacrificed.
- If we do relinquish any services, appropriate access needs to be a priority.
- As mentioned an affiliation with a major teaching facility on the mainland would be of benefit for resourcing and networking.
- Need to improve access to Mental Health Service in Tasmania in general, they do not work well with hospitals, very poor access for community care.
- Community should have access to those services that are considered 'mainstream' in most health areas in relationship to the regionality of the services, ability to sustain efficient, quality, safe services, distances to travel etc. In the north west, joint surgery is a typical example. If routine knee replacement was withdrawn from the scope of NWRH, would this be seen as a sensible decision.

Acknowledgements

This submission would not have been possible without the support and contributions of a number of people and THO-North West apologises in advance, if it has not listed all those who contributed to this paper.

- All THO-North West staff who contributed to this paper
- Adjunct Associate Professor Karen J Linegar, Acting CEO, THO-North West
- Dr Deborah Hickling, Clinical Leader Obstetrics and Gynaecology, THO-North West
- Dr Marielle Ruigrok, Clinical Leader Emergency Medicine
- Dr Sheryl Sim, Consultant oncologist, THO-North West
- Assoc Prof Michael Buist, Clinical Leader Critical Care Unit
- Dr Paul Greham, Oral Health Services Tasmania senior clinician
- Professor Michael Ashby, Clinical Director, Complex and Chronic and Community Care and Palliative Care, THO-South.
- THO-North West Medical Advisory Committee members
- Dr Wayne McDonald, Acting Executive Director of Medical Services, THO-North West
- Jo Reid, Acting Executive Director of Nursing and Midwifery, THO-North West
- Paula Hyland, Director of Allied Health, THO-North West
- Denise Parry, General Manager, North West Regional Hospital, THO-North West
- Eric Daniels, General Manager, Mersey Community Hospital, THO-North West
- Sue Wyeth, General Manager, Mental Health Service, THO-North West
- Barbara Ringeisen Arnold, Director eHealth, THO-North West
- Brendan Holland, Director Human Resources, THO-North West
- Anne Cabalzar, Director Accreditation and Service Improvement, THO-North West
- Katrina Willis, Co-Director Regional Perioperative Services, THO-North West
- Donna Harris, Medical Services Unit manager, THO-North West
- Angella Downie, Co-director Chronic Complex and Community Services, Primary Health Services, THO-North West
- Jacky Taylor, Acting Co-director Chronic Complex and Community Services, Primary Health Services, THO-North West
- Tana Clark, Infection Prevent & Control service, THO-North West
- Annette Edwards, Occupation Health Nurse/Clinical Nurse Specialist, THO-North West
- Julie Milnes, Health Promotion Coordinator, Primary Health Services, THO-North West
- Kim Miles, Regional Transport and Patient Services manager, THO-North West
- Fleur King, Media and Communications manager, THO-North West

Ends.