

DELIVERING SAFE AND SUSTAINABLE CLINICAL SERVICES

WHITE PAPER – EXPOSURE DRAFT
MARCH 2015



Foreword

This Exposure Draft of the White paper (Exposure Draft) outlines how we will reform the design of the Tasmanian health system to deliver better health services and help us to realise the vision we have for Tasmania to have the healthiest population in Australia by 2025.

Tasmania's health system is broken and needs to change.

This is not about saving money, it's about improving patient outcomes.

As a result of the changes outlined in this document our health system will operate as one single statewide system, with each hospital having an important but different role to play.

Hospitals will specialise in the procedures they are best suited to provide and patients will go to the hospital which is expert in what they need.

Also, transport and accommodation support will be provided to help people who may have to travel to get the best quality healthcare.

Tasmanians care passionately about their health system and have engaged in the *One State, One Health System, Better Outcomes* reforms in an unprecedented way. We began by consulting more than 170 nurses, doctors and other key stakeholders. This has been followed by discussions with more than 200 members of the community who have attended public forums around the state to take part in consultations and provide feedback on the Green Paper. In addition, approximately 180 written responses have been received in response to the Green Paper.

It is clear from this feedback that Tasmanians recognise that, despite the best efforts and professionalism of our health workforce, the health system is letting them down and needs to change.

This Exposure Draft outlines a health reform package that will deliver improved safety and quality of services, greater efficiency so that we can provide more services to the community with the resources that are available to us, and improved patient support to enable access to the improved services. This is a shot in the arm for our health services.

Safe, high quality health services characterised by effective and efficient clinical care delivery require a health system that is designed, governed and managed to deliver these outcomes.

We know that everyone in the system is committed to providing safe, high quality services. There are times however, when we are asking people to deliver health services without the appropriate support required to make the service safe.

Designing the system is an essential step in delivering good health care. Just as you wouldn't start to lay the bricks without having an overarching design for a new house, we shouldn't simply add pieces to the health system structure without having a clear, overall plan.

The health system has many parts that must work in harmony to provide optimal outcomes for the community. The acute public hospitals are just one part of this system, which also includes primary and preventative care, community care, aged care, private providers, research activity and the education and training of our health professionals.



Hon Michael Ferguson MP
Minister for Health

We acknowledge that there is a strong focus on the acute hospital system in the Exposure Draft. This is because this is where we need to direct our focus initially to make the system safe. As our reforms progress into the primary and community sectors, we will be moving the system toward sustainability and achieving our vision of having the nation's healthiest population.

The health reform package includes a new design for the services our acute hospitals provide together with a clear, long term role for each hospital within the overall Tasmanian health system. This design is based on the best available evidence on what will provide safe, high quality health services to the Tasmanian community and has been developed in consultation with clinicians, the broader health workforce and the community.

In addition, we continue to recognise the importance of prevention and the role of primary and community health in achieving this vision. That is why we have developed a new preventative health policy, *A Healthy Tasmania*, and will be actively working with our partners in primary health and the community sector to firmly embed this in our system.

Similarly, the *Rethink Mental Health Project* is a key aspect of the government's commitment to an integrated Tasmanian mental health system that provides support in the right place, at the right time, and with clear signposts about where and how to get help. The *Rethink Mental Health Project* will provide better outcomes for consumers, their families and their carers.

Importantly, redesign of the health system will ensure that we spend our existing health funds more efficiently, including by providing improved surgical services to deliver cost benefits. This will free up existing funds that will allow us to:

- address known gaps in health services in our local communities
- enable the treatment of more people meaning reduced waiting times for access to treatment and reduced waiting lists, and
- direct health spending and activity towards the interventions that are shown by evidence to provide the greatest benefit to patients and the community.

A design for the clinical services provided in the health system is not enough on its own. This is why we have announced significant changes to the way our health system is governed and managed. The Tasmanian community can be assured that our health system will operate as a cohesive whole, providing access to better services and better outcomes.

Better governance will be provided through the creation of a single Tasmanian Health Service (THS), in place of the existing three regional Tasmanian Health Organisations (THOs). This is a vital step in creating a seamless health service and making sure there are not wasteful duplications in the system allowing more of our health funds to be used for better patient outcomes.

We are one State and by developing one single cohesive health service, we can build the health system Tasmanians deserve. This single service will importantly deliver safer health services when Tasmanians need them by the right team of health professionals.

Hon Michael Ferguson MP
Minister for Health

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Executive Summary

The *One State, One Health System, Better Outcomes (One Health System)* reform program is the first vital step in designing a health system that functions effectively as a true statewide service.

Tasmania will have one health system, one primary health network (PHN) and one university, including the Menzies Institute for Medical Research. This provides an unprecedented opportunity to achieve true health reform supported by a well trained workforce and driven by evidence based innovations.

This stage of the reform process focusses heavily on our four major acute hospitals and each facility clearly working to its defined role in the system. This does not discount the role and importance of the other parts of the health system, rather it is an acknowledgement of the persistent issues that Tasmania has faced in the delivery of acute hospital services.

It is clear that the division of Tasmania's acute health service into three distinct management structures has been a barrier to our hospitals working together to deliver optimal care for all Tasmanians. This has led to safety and quality issues in some areas, duplication of services resulting in inefficiencies, identifiable service gaps and higher costs that limit our ability to deliver the range and volume of services that Tasmanians need.



A true statewide service.

Securing safe health services

The first phase of acute system reform is to define the capacity and capabilities of our health facilities to provide safe and sustainable clinical services of defined complexity. This is achieved through the development of a Tasmanian Role Delineation Framework (TRDF), followed by mapping of services to determine a valid Tasmanian Clinical Service Profile (TCSP).

Simply put, this process tells us how to configure our services more effectively to provide better outcomes for patients, by ensuring:

- high quality health services that are only delivered where appropriate support services are available
- access to better care, as opposed to better access to care, and
- more efficient services with less duplication, freeing up resources to provide more services that the community needs and cannot currently access.

The development of the TRDF and the TCSP has been undertaken in partnership with clinicians and the community through a consultation process that has been supported by an Issues Paper and a Green Paper.

What has become abundantly clear is that change is required to achieve the better health outcomes that our community both expects and deserves.

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It is clear that all four of our acute hospitals are rightly valued by their communities, and play an important role in delivering an integrated suite of safe and sustainable health services to the population.

Building confidence in our hospitals

There is a set of proposals in this Exposure Draft that, when taken together, will cement the role of all four hospital facilities by defining their role in the system:

- The North West Regional Hospital (NWRH) will build on its role in providing acute general hospital services to the North West region.
- The Mersey Community Hospital (the Mersey) will continue to provide a mixture of general hospital services to the local community as well as playing a vital role in a statewide hospital service network.
- The Launceston General Hospital's (LGH) role as the principal referral hospital for the North and North West of Tasmania will be strengthened. It will provide a number of tertiary services. Greater attention will be given to using the services and expertise at the LGH to support quality services across the North and North West.
- The Royal Hobart Hospital (RHH) will continue to be the principal referral hospital for the South and will also provide a number of tertiary services for the State.

Establishing an elective day surgery centre at the Mersey

Surgical services are clearly not currently operating as well as they could in Tasmania. We have burgeoning waiting lists, patients waiting unacceptable times for surgery, high cancellation rates and poorer outcomes than other jurisdictions.

This reform provides an opportunity to build an elective day surgery centre at the Mersey, supported by specialist surgical staff from across the State. This would be a keystone to improving Tasmania's elective surgery performance. Too often in our current system elective surgery is cancelled due to overriding emergencies. A dedicated elective day surgery service will assist in overcoming this problem.

A number of changes at the Mersey will result in a decrease in the complexity of some services provided. The current High Dependency Unit (HDU) will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre. These changes have been recommended by senior clinicians working in the region, due to concerns about safety and the quality of care that is able to be provided from the HDU as a result of a number of factors. These factors include low numbers of patients being managed in the HDU and ongoing recruitment difficulties resulting in high numbers of locum staff.

Surgical services are clearly not currently operating as well as they could in Tasmania.

Providing more services across the North and North West

With resources in the North West going into expensive services that are used by very few people, there are service gaps in clinical areas that impact on a large numbers of patients. Examples include pain medicine, rheumatology, neurology and rehabilitation services. As a result, some people are missing out on the services that they need access to closer to home. These are the sorts of services that people may require for an extended period of time.

The Mersey will have an enhanced role in providing subacute services such as palliative care, rehabilitation and geriatrics to the community of the North West. These are all important services that will be vital for the wellbeing of an ageing population with a high burden of chronic disease.

The LGH and RHH will provide greater outreach support services to patients in the North West. This will enable some new services to be provided in the North West, such as rheumatology and pain management and urology, and access to better care in surgery, medicine, rehabilitation, geriatrics care and oral health.

The LGH and RHH will become hubs for managing integrated cancer services across the State. The Northern Integrated Cancer Service will manage the provision of more cancer services across the North West, including providing the support required to open the new radiation oncology service at the NWRH.

Building better, more sustainable services

The reforms proposed seek to build services that have adequate volumes for high quality, sustainable services.

The proposals support the development of new integrated services that address service gaps and promote better outcomes for patients requiring complex services. This is particularly the case where evidence strongly indicates that better outcomes can be achieved by concentrating greater patient numbers in fewer locations.

There will continue to be some services that are delivered on a statewide basis. These are very high complexity, low volume services requiring significant specific clinical supports, and can only warrant one team of health professionals providing care at one site. These services currently include cardiothoracic surgery and neurosurgery, both of which are proposed to remain at the RHH. It is proposed that high complexity upper gastrointestinal surgical services are also provided through a single site in order to improve the safety and quality of care delivered to patients requiring these services. There are two options for the consolidation of these services, the RHH or the LGH. While there are significant benefits for consolidating this service in Launceston, there are complexities that need to be resolved in consultation with the Tasmanian Statewide Surgical Services Committee (TSSSC).

There is also a set of services, including cancer services, where there has been ongoing difficulty in managing and delivering separate services in the North and North West of the state. When taken as a whole, the northern population can support these services. For this reason, the Northern Integrated Cancer Service, operated from the LGH, will provide better integrated services across the North and North West of the State. Through the development of a critical mass of specialist workforce, the new linear accelerator will be opened and operated at the NWRH to provide vital radiation oncology treatment to cancer sufferers.

We already utilise interstate expertise for the management of some patients with high complexity conditions, and this will continue wherever the low volumes of certain conditions cannot support the safe or efficient delivery of services locally.

Supporting the reforms

The implementation of these reforms will result in increased movement of both patients and health professionals, in particular across the North and North West, as the system becomes more integrated and all acute hospital facilities are more effectively utilised.

That is why the proposed changes will be complemented by improved transport and accommodation support for patients and their families. Doctors, nurses and allied health professionals will also be supported to travel to provide services closer to where patients live.

Public-private partnerships help us to deliver services where there are not enough resources to 'go it alone', and where duplication of services within both the private and public systems is not sustainable.

The ongoing pursuit of innovative change will support a constantly improving and adapting health system. Making better use of our health professional workforce, by introducing new models of care that use the full range of their skills and expertise, in particular in the nursing and midwifery workforce, has the potential to provide a more efficient overall health service.

Supporting the *One Health System* changes is a governance structure that will provide leadership and stewardship of the health system. It will have greater accountability and transparency, be effective, efficient and importantly, participatory. This means Tasmanians can look forward to a single statewide Tasmanian Health Service that will break down the existing barriers to providing better health services for all Tasmanians.

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Introduction

The *One State, One Health System, Better Outcomes* reform program is about getting the best outcomes for all Tasmanians from the health resources available.



In September 2014, the Tasmanian Government released an Issues Paper to prompt community discussion on the challenges that we face in our health system. In December 2014, the Government released a Green Paper that included a draft role delineation framework and some direct questions to guide consultation on the future of Tasmania's health system.

Submissions to the Green Paper process, including those from the Clinical Advisory Groups (CAGs), have identified a significant number of potential improvements to specialty services. Many of those relevant to the Tasmanian Clinical Services Profile have been captured in this Exposure Draft. A number of recommendations put forward will be referred to the Governing Council of the new THS to be considered in the process of establishing statewide clinical services, or as an aspect of ongoing service improvement processes.

This reflects an important message- the process of reform is never finished. While the suite of proposals and decisions reflected in this Exposure Draft you now hold represent the most substantial clinical service profile reform seen in Tasmania in decades, the delivery of health services to any community has to be characterised by continuing introspection, self-challenge, improvement and redesign. A health system that stands still is a health system that can only respond to the challenges of the past.

Key messages from the consultation have included:

- The processes for delivering hospital-based care need to be reengineered to focus on achieving the best possible outcomes for all Tasmanians.
- The profile of services around the state should be based on evidence, interpreted in the context of Tasmania's need.
- We need to support the patient journey, particularly if services are provided outside of the region in which they live, including ensuring that:
 - transport and accommodation policies are focused on support for patients and their families
 - IT systems (eHealth) support access to patient information and coordination of services, and
 - strategies are developed to support access to and use of telehealth.
- The Government's reform agenda needs a greater focus on health promotion and prevention.
- A strong primary care system is an essential part of a high performing health system.
- Coordination of care and communication need attention if demand for services is going to shift from the hospitals to community services.
- Consumer engagement and buy-in are critical at all levels of the reform program

- Better linkages are required between State and Federal bodies to improve patient outcomes and ensure access to seamless healthcare e.g. aged care, disability and health.

The decision to release this Exposure Draft of the White Paper addresses a number of key issues identified in the first round of consultation:

- we need to be specific about the proposed changes and provide everyone with an opportunity to comment
- we need to continue to build on our consultation to date, including through more structured and targeted consultation with nurses, allied health professionals and doctors, and
- we need to understand the implications of the changes that are proposed, so we can identify the challenges that must be overcome to support access to services.

During the months of April to June 2015, the Department of Health and Human Services (DHHS) will lead a further round of consultation with key stakeholders on the proposed changes. This consultation will include:

- a second round of public and staff forums to provide information on the outcomes of consultation to date and to seek comments on the proposed changes
- a dedicated round of consultation with key stakeholders, with increased attention being given to the views of nurses and allied health professionals, and
- receiving any further written input.

We will also explore opportunities for targeted discussions with stakeholders around the more significant changes proposed in the Exposure Draft.

The *One Health System* reforms are about doing more with our current resources. It is about improving the safety, quality and range of public health services by targeting inefficiencies that we know are in our current system.

With a greater understanding of *what* we want to achieve, we will work with stakeholders on *how* we are going to achieve it. This includes understanding how we redirect resources within the system to deliver on the many improvements identified in the Exposure Draft. In June/July, we will be able to detail the final decisions on changes to the profile of services in Tasmania, but importantly also how we can afford to deliver these changes.

*With a greater understanding of **what** we want to achieve, we will work with stakeholders on **how** we are going to achieve it.*

I. Time for change

The Government's vision for Tasmania is 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 challenges facing Tasmania's health system have been persistent and endemic and we are currently a long way from achieving this goal.

In response to the Issues Paper and the Green Paper, the community and clinicians have overwhelmingly told us they support change in the system.

I.1 Tasmania's health status

The health of Tasmanians is improving, with longer life expectancy and better self-reported health than a few years ago. Progress has been made in prevention and earlier disease detection and treatment, with comparatively high levels of participation in cancer screening and primary care consultations, and declining rates of potentially avoidable deaths and potentially preventable hospitalisations.

However, progress towards healthier lifestyles in Tasmania remains mixed and the increase in chronic conditions adds to the burden of disease and increasing demand for health services. Much remains to be done to achieve a 'healthy Tasmania', and the time to take action is now.

Although life expectancy has improved since the 1980s, Tasmania continues to have a lower life expectancy than almost all other Australian jurisdictions. The life expectancy of Tasmanians in 2013 was below the national life expectancy by 1.3 years for males and 1.7 years for females.

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Figure I.1.1: Life expectancy at birth by jurisdiction, 2013 Source: ABS, Deaths Australia 2013

Tasmania continues to have higher rates of smoking than most other states and territories. According to the latest national health survey, about one in five Tasmanian adults smoked in 2011-12 compared to 18 per cent of adults nationally. Although smoking during pregnancy is gradually declining in Tasmania, maternal smoking remains a health problem with around 16 per cent of Tasmanian women continuing to smoke during their pregnancy in 2012.

Almost two thirds of Tasmanian adults were overweight or obese in 2011-12, of which over one in four Tasmanians (27.8 per cent) recorded as obese. Nationally, there has been a steep increase in combined overweight/obesity over time, from 38 per cent in 1989-90 to 62.8 per cent in 2011-12. Obesity rates have tripled from 9 per cent to 27.5 per cent over the same period.

Tasmanian population health surveys conducted in 2009 and 2013 show an increase in the lifetime prevalence of chronic conditions since 2009 for several chronic conditions, including hypertension, asthma, diabetes, cancers, arthritis, and heart disease. In 2013, hypertension was reported by 31.1 per cent of the adult population, arthritis by 28.1 per cent, heart disease by 8.5 per cent, and diabetes by 7.6 per cent of adults.

There has been a downward trend for hospitalisations and mortality for some chronic conditions such as strokes and ischaemic heart disease, but morbidity and mortality have increased for several other conditions.

Tasmania's age-standardised mortality rate for ischaemic heart disease and cancers are significantly higher than Australian rates, and hospitalisations have increased for arthritis.

We know that health sector policy, planning and delivery can impact both positively and negatively on equity in health outcomes. We also know we must commit to addressing life risks (the conditions in which people are born, grow, are educated, live, work and age) and the contribution of these factors to health inequity. To address detrimental influences, action is needed that focuses on the complex causes of poor health. Much of what influences health status, for example, lies outside of the control of the health sector.

1.2 Health system challenges

A failure to approach system-wide reform strategically and systematically has meant that the challenges facing the system have continued, and the poor health outcomes for Tasmanians have persisted.

The pressure on the health system is not likely to decrease in the near future, with a predicted quadrupling of the population aged over 85 and a doubling of those aged over 65 by 2056.

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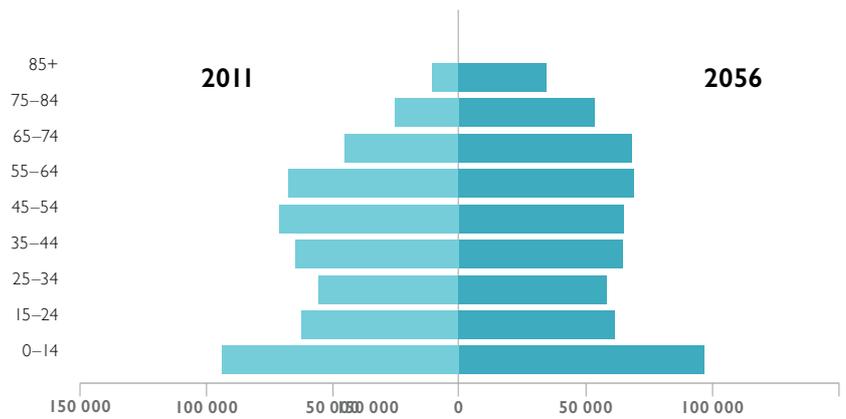


Figure 1.2.1: Population projections 2006-2011

Source: ABS Population projections 2006-2011

Health costs have continued to rise and utilise an increasing proportion of government expenditure at both a State and Commonwealth level.

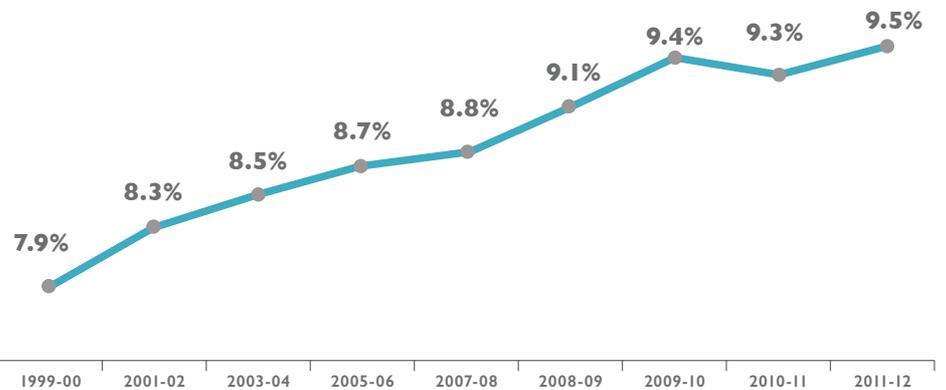


Figure 1.2.2: AIHW, Australia's Health 2012, Health spending, GDP ratio Australia

Source: AIHW, Health Expenditure Australia, 2011-12, p.8

This trend in increasing expenditure has been manageable in the past, because budgets have also grown over the same period. Difficulties with sustainability will occur if these long term trends in health expenditure growth continue.

1.3 Current health system performance

By a number of measures our health system is not performing well.

Waiting times for elective surgery are by far the worst of all Australian states and territories and differ depending on where in Tasmania you live.

The number of people waiting longer than clinically recommended times at the LGH and RHH are significantly higher than at the NWRH and Mersey.

Tasmania has the highest rate of adverse events within its hospitals, leading not only to poor patient outcomes, but also to higher costs.



Figure 1.3.1: Adverse Events per 1000 Separations

Source: Department of Health and Human Services

Tasmania has the highest rate of unplanned readmissions due to a post-operative adverse event for some procedures nationally, such as for hip replacement, hysterectomy and prostatectomy.

In some areas of the health system there are systematic failures in safety and quality. Patients are experiencing needless harm, sometimes resulting in potentially avoidable death.

The costs of delivering services in our acute hospitals are higher in Tasmania than other states, in particularly in the North West. The two North West hospitals are the most expensive hospitals in Tasmania to provide health services. The figures below illustrate the increased costs at the NWRH.

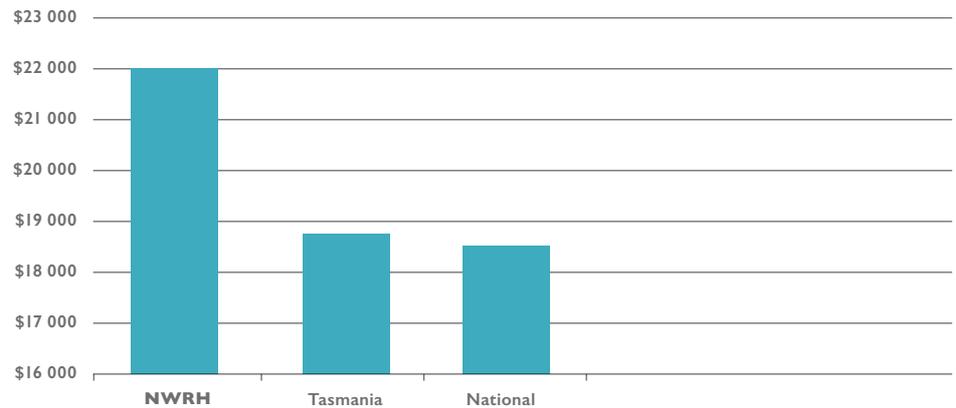


Figure 1.3.2: Cost comparison- knee replacement

Source: National Hospital Cost Data Collection, 2012-13.

Medical staffing costs in the North West are very high. The North West region currently spends in excess of \$10 million annually on locums to support the delivery of clinical services, many of which could be provided better and more sustainably by specialists currently employed in the Tasmanian system. Through greater collaboration across the regions, we must reduce these unnecessary costs so that we can invest in better services for all Tasmanians, including new services in the North West.

These are examples of the significant evidence that, when taken as a whole, clearly demonstrates the case for change if Tasmania's health system is to operate in a sustainable way, providing safe and equitable care that meets the needs of all Tasmanians.

If we continue to do things the same way, then we can only expect the same unacceptable health outcomes for our population.

2. Designing a better health care system

Tasmania's Health System Profile

Tasmania has 27 public and 14 private hospital and health facilities. In addition to the four major hospitals, there are 23 rural and community hospital sites (rural health services) across Tasmania. The services provided at these sites vary considerably and include subacute inpatient health care, day treatment and primary health care services, residential aged care and emergency response capability.

In the primary health system there are:

- 590 general practitioners (GPs) and 320 practice nurses delivering services in 167 general practices in urban, rural and remote areas of Tasmania
- 2 141 allied health practitioners, including but not limited to professions such as physiotherapy, exercise physiology, psychology, optometry and dentistry- the majority of whom work in community based settings
- 676 pharmacists delivering services through 148 pharmacies across Tasmania
- 38 residential aged care organisations delivering residential and community care services through 78 residential facilities, along with over 20 community care providers
- a range of services delivered through seven Aboriginal organisations located across Tasmania, four of whom have access to general practice services onsite
- a broad range of providers delivering community and social care services to patients and their carers and families, and
- key organisations leading to policy and action on preventative health priorities and initiatives.

Tasmania provides health professional training across a broad range of professions through the University of Tasmania and the Vocational Education and Training sectors. The Menzies Institute for Medical Research is a world class research facility that is based in Hobart and is an institute of the University.

Of the public hospitals, the RHH, LGH, NWRH and the Mersey accepted more than 95 per cent of the public hospital admissions in 2011-12¹.

To improve the quality, safety, effectiveness and efficiency of the health care system in Tasmania, we must actively design a system that achieves those outcomes, rather than continuing with a business-as-usual approach.

The *One Health System* reform program promises a health system that functions effectively as a true statewide service, with each facility clearly working to its defined role in the system. This section outlines the early actions that need to be taken to achieve that.

¹ Report of the Commission on Delivery of Health Services in Tasmania - April 2014

Rheumatology and pain management commence at level 4 within the Tasmanian Role Delineation Framework with no recognition of the role general practitioners or broader primary health services have in caring for patients with these conditions on a daily basis.

Tasmanian Medicare Local

Firstly, this section outlines a design for safe and sustainable services in our four acute hospitals. This design is the result of the development of a Tasmanian Role Delineation Framework (TRDF) for clinical services and the application of this framework to develop the Tasmanian Clinical Services Profile (TCSP) of each of our clinical services in each hospital campus.

The development of the TRDF and TCSP have been undertaken through intense consultation with clinicians and the community and has been guided by the following principles:

- Placing patients first by ensuring a clearly defined pathway to the most appropriate care.
- Providing holistic, evidence-based health services that deliver the best patient outcomes at affordable costs.
- Strengthening the safety and efficiency of delivered clinical services through an agreed role delineation framework.
- Improving the quality and safety of care by ensuring agreed standards are met and minimum service volumes are maintained.
- Strengthening the role of DHHS as the system manager to plan the arrangement, location, type, and quality of clinical services.
- Providing a process for accessing more complex care in the community.
- Ensuring that the health workforce has the appropriate skill mix, and is supported to sustain clinical and professional competence.
- Exploring partnerships with primary and private health providers.
- Providing agreed definitions for health care providers and planners.

Secondly, this section looks at the importance of prevention and the primary care system in designing a strong and sustainable health care system. It outlines steps that can be taken to support access to services where they can't be provided safely or sustainably at a local level.

Finally, the important interface between the public and private sectors is outlined, identifying opportunities to strengthen public-private partnerships.

2.1 Strengthening our acute care system

Our major hospitals have long operated as semi-independent single or regional entities, with a limited coordinated statewide focus. This limited integration has led to a lack of alignment between service delivery and community needs.

As a single health system, under the THS, each and every clinical discipline will have a statewide focus. For example, we will have one statewide emergency service, with care delivered to patients across four large hospitals and many smaller rural hospitals. What this means is that a patient presenting for emergency care (whether it be in Launceston, Burnie, Hobart or Devonport) can expect consistent clinical practice, and a comparable service, delivered within the effective scope of that facility's clinical practice.

We will have one statewide cardiothoracics service, with surgical care delivered at the RHH but outreach support provided to all sites for the clinical management of patients where cardiothoracics expertise is required.

The first phase of fixing the current system is to define the capacity of our health facilities to provide safe and sustainable clinical services of a defined complexity. This is undertaken through the development of a TRDF, followed by an analysis of the services to determine the optimal current clinical service profile.

The Tasmanian role delineation framework (TRDF)

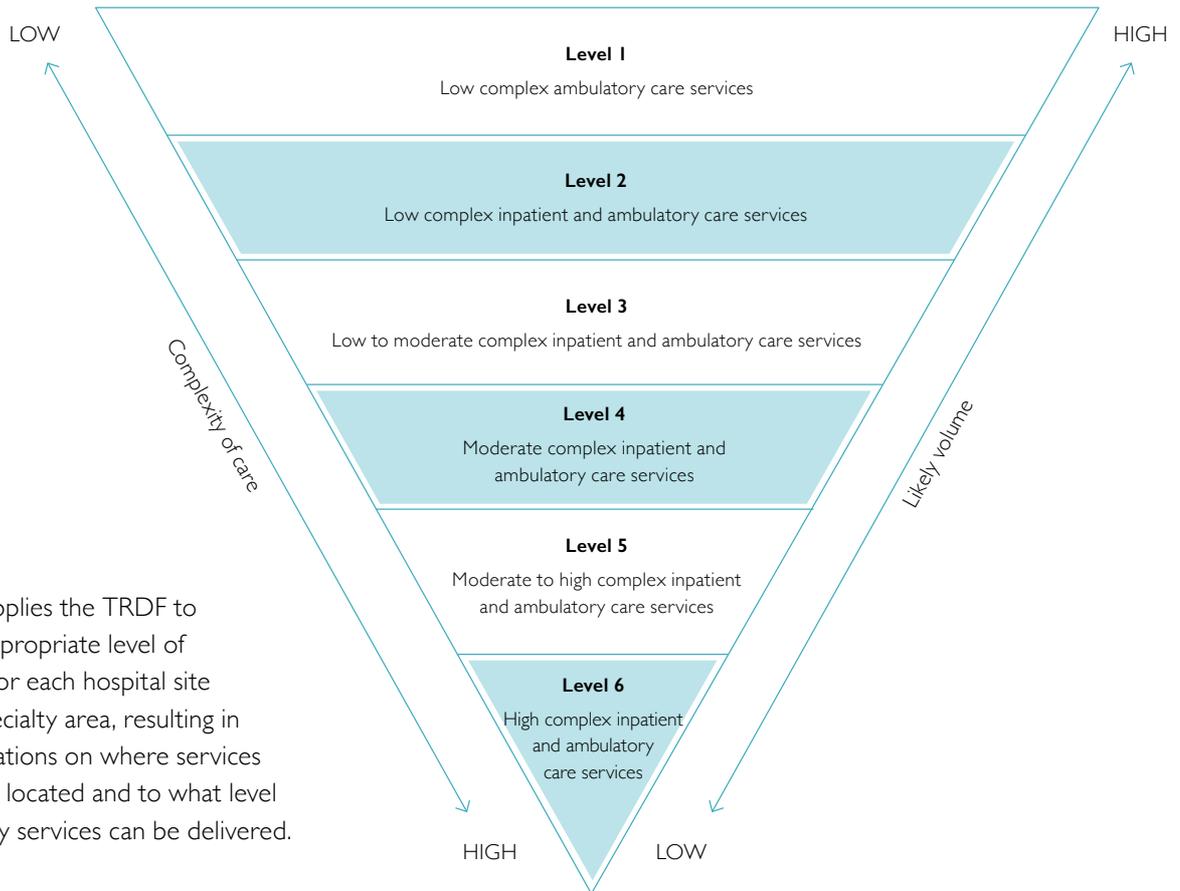
The Tasmanian role delineation framework (TRDF) describes the various levels of a clinical service, including the supports required to function safely and effectively. It then defines the capacity of a given health facility to provide clinical services of a defined complexity.

It recognises that for each level of clinical service provision, corresponding clinical support and staff profiles are required to ensure services are delivered in a safe, efficient and appropriate manner. The volume of activity is also an important factor in determining the appropriate level of service.

The TRDF has been developed through utilising best available evidence, including consultation with Tasmanian clinicians.²

The defined levels of complexity in the TRDF range from level 1 up to level 6. There are increasing requirements for specialised workforces, infrastructure and support services required with increasing complexity.

Tasmanian role delineation framework service (TRDF) complexity levels



The TCSP applies the TRDF to assign the appropriate level of complexity for each hospital site and each specialty area, resulting in recommendations on where services can be safely located and to what level of complexity services can be delivered.

Tasmanian Clinical Services Profile

	RHH	LGH	NWRH	MCH
Anaesthetic Services	6	5	4	3
ICU/HDU	6	5	4	3
Pathology	6	5	4	3
Pharmacy	6	5	4	3
Medical Imaging Services	6	5	4	3
Emergency Medicine	6	5	4	3
Trauma Services	6	5	4	3
General Medicine	6	5	4	3

The level assigned to each hospital needs to be read in conjunction with the level of complexity outlined in the Tasmanian role delineation framework.

Level 6 Intensive Care Unit / High Dependency Unit – Service description

A level 6 service provides services at level 5 plus it is the highest level referral unit for intensive care patients and is capable of providing comprehensive critical care, including complex and multisystem life support for an indefinite period, and support for complex level 6 activity. A level 6 ICU should contain and be supported by services that provide patient care at a level which delivers appropriate clinical services for all types of illness/injury, other than those which the State does not support such as acute transplantation medicine. As such a level 6 ICU should not require transfer of acute patients to other ICUs except for times of significant bed pressure. However, elective transfer of patients to other ICUs within the State should be supported where services exist to support the patient, and the transfer facilitates better proximity to the patient's family.

The recommendations in the TCSP are based on feedback from consultation, discussions and submissions from all stakeholders. This feedback covered six important themes:

- Patient outcomes – Patient outcomes at individual clinician, unit and facility levels.
- Access – Patient experience including access and wait times.
- Best practice – National and international standards and best practice.
- Workforce – Workforce needs and availability, including education and training, qualifications and ongoing professional development.
- Service capability – Support services and equipment required.
- Safety and Quality – Risks to the patient, organisation, and system.

The TRDF and the TCSP are working documents that will be finalised upon release of the White Paper. Even so, to remain relevant they will regularly be reviewed and updated to reflect changes in service requirements, facility capability, technological and service innovation, and community need.

For the most part, services currently being delivered will not change. The majority of clinical services in Tasmania will continue to be provided at the current service complexity.

There are a number of changes that have been identified through this process that would make the system safer and more sustainable within the resources that are currently available. These changes are outlined below in two ways:

1. specific service issues that have been identified as requiring change, and
2. specific proposed changes for each of the four large hospitals.

The following section describes the level of clinical service provided in each of the four acute hospitals.

These levels are defined in the TRDF. A copy of the TRDF can be found at: www.dhhs.tas.gov.au/onehealthsystem

The TCSP is provided at Appendix I.

The Way Forward

Continue to consult with allied health, nursing and medical workforce to build a more comprehensive Tasmanian role delineation framework.

The Way Forward

Work with the Tasmanian Statewide Surgical Services Committee (TSSSC) and the Tasmanian Health Service (THS) to create the integrated northern surgical service.

Undertake consultation with the TSSSC to determine the optimal service configuration for upper gastrointestinal surgery.

2.2 Key service issues

A number of services have been identified where key changes to services are required to ensure that the state is delivering evidence-based, high quality and safe care. They include changes to:

- surgical services
- integrated cancer services
- trauma and critical care services, and
- subacute care services.

There are a number of other services where it is clear that change is required; however there is more work to be done before final recommendations can be made in:

- maternity and neonatal services, and
- burns services.

Further detail on each of these services is provided below.

2.2.1 Surgical services

Surgical services are currently provided at all four of the acute public hospital sites. While surgical activity of appropriate complexity should be maintained at each facility, the level of collaboration between facilities must be increased, and the scope of surgical procedures at each facility should be based on a clinical determination on what is safe and sustainable. This will include ensuring surgical services are delivered within the assigned clinical service level.

There are significant regional differences in the costs of delivering services in some areas. Compared to the cost of delivering surgical care at the LGH, it is 16 per cent more expensive at the NWRH and 13 per cent more expensive at the Mersey. The differences are particularly high for some surgical procedures. It is 68 per cent more expensive to perform a knee reconstruction at the NWRH than at the LGH and 63 per cent more expensive to perform a tonsillectomy at the NWRH than at the LGH. While it is expected that there would be some variation due to service volumes and the fixed costs of facilities, such large differences can only point to systemic problems with how the health system is structured and operated.

It is proposed that an integrated northern surgical service managed from the LGH and operating across the North and North West is created to increase access to specialist services in the North West, and reduce the disparity in costs between the NWRH, Mersey and LGH.

The *One Health System* reforms will foster greater collaboration between surgical services across the state, with the initial priority being collaboration across the North and North West. Surgical services working together will improve the quality and safety of the services across the state, improve access to some services in the North West and build a larger, more sustainable surgical service for Tasmania. This will have the added benefit of reducing the state's reliance on expensive locum specialists. The volumes and range of complexity of the services delivered across the two regions will also assist with attracting and training surgeons with specialist and generalist skills.

Safety is a key driver for defining the scope of surgical procedures that will be allowed at each hospital. Across surgical disciplines, patients with more complex conditions will need to be transferred from the NWRH to the LGH to ensure surgery is provided in a facility where support services are available to best manage recovery and deal with complications. There will also be a focus on promoting outreach services from Launceston into the North West to reduce the need for patients to travel to Launceston on all occasions. Where clinically appropriate, the use of telehealth facilities³ will also be promoted, so that patients can access health services without having to leave their home or local community.

It is proposed that, in addition to core services such as emergency care, the Mersey is developed as an elective day surgery centre. This will serve to:

- help to reduce unacceptable waiting times for surgery by moving elective day surgery to a dedicated facility that won't be subject to interruptions caused by emergencies, or be affected by bed occupancy issues
- increase both the safety and efficiency of day surgery performance, by concentrating a greater proportion of day surgery at the Mersey, consequently increasing the critical mass of services and introducing economies of scale
- increase capacity in other sites for performing more complex surgery by moving less complex cases to another facility, and
- accommodate targeted short term investment to improve elective surgery waiting times in areas of high demand.

There will continue to be some services that are delivered on a statewide basis. These are very high complexity, low volume services requiring significant specific clinical supports, and can only warrant one team of health professionals providing care at one site. These services currently include cardiothoracic surgery and neurosurgery, both of which are proposed to remain at the RHH.

High complexity upper gastrointestinal surgical services are currently being provided at both the RHH and the LGH. It is proposed that these services are provided through a single site in order to improve the efficiency and sustainability of care delivered to patients requiring these services. Options for the consolidation of these services include the RHH or the LGH and are being considered in consultation with the Tasmanian Statewide Surgical Services Committee (TSSSC). There are significant benefits to consolidating this service in Launceston, however service complexities need to be assessed before a final decision is made.

3 The International Organisation for Standardisation defines Telehealth as the 'use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance'

Improving the efficiency of theatre utilisation

Many stakeholders have contributed comments on the inefficient use of operating theatres in the public system. For example, the Musculoskeletal Medicine CAG identified that postponement or cancellation of elective surgery (often due to emergency procedures) significantly contributed to the costs of orthopaedic surgical procedures. In part, this is because delays to elective surgery often led to the deterioration of the condition of patients on elective surgery waiting lists, with more invasive surgery required or complications developing.

Similarly, many clinicians have identified the inefficient management of patients and patient records as a significant contributor to avoidable surgical costs. While patient changeover in the private sector can be managed in terms of minutes, there can at times be delays of over an hour or more within the public system.

Improving the management of surgical theatres will both improve the outcomes for patients and reduce the costs for the public health system. These costs will be redirected to providing increased volumes of surgery, thereby reducing waiting times further.

The increased utilisation of the Mersey for elective day surgery procedures will reduce the pressures on theatre services at the LGH, NWRH and RHH and reduce the competition between elective and emergency procedures. The establishment of the THS will also improve the efficient use of operating theatres through improved patient management and, over time, improved and consistent management of patient records.

the patient journey

Now

Mike is a 60 year old mechanic from Launceston. He has had crippling wrist pain and pins and needles in his hand due to carpal tunnel syndrome for two years. He frequently drops his tools, and some days cannot work at all.

Mike has been on the waiting list for a carpal tunnel release for 18 months. In the last six months, Mike has been called up for elective surgery by the LGH twice. Both times he took time off from work, arranged care for his pets and was admitted to the hospital for his operation.

Unfortunately, Mike's surgery was cancelled on both occasions due to other emergencies arriving, and he was sent home without being provided with a date when he would actually get his surgery.

One Health System

Mike has his surgery scheduled at the Mersey elective day surgery centre. He is provided with four weeks' notice and information about how his transport from Launceston to the Mersey can be supported, and reassured that his surgery would not be cancelled as the Mersey surgical services are not interrupted by emergency surgery.

Mike travels to the Mersey, has his procedure by the surgeon from Launceston (who had also travelled to the Mersey to undertake cases for the day) and returns home later that day.

2.2.2 Integrated cancer services

'Cancer Services' are the specialised services that diagnose and treat cancer and cancer survivors. In the acute hospital sector this includes medical oncology services, radiation oncology services and haematology.

- Medical Oncology is the assessment and treatment of patients with cancer, particularly through the use of systemic therapies (such as chemotherapy).
- Radiation Oncology plays a major role in cancer treatment. Radiation therapy is either used alone or combined with surgery, chemotherapy, or other therapies in the cure or palliative treatment of cancer.
- Haematology is concerned with the study of blood, the blood-forming organs and diseases of the blood. This includes the diagnosis and treatment of haematological cancer (such as leukaemia), as well as non-malignant haematology.

Outcomes for Australian cancer patients have improved dramatically over the past 20 years. Current survival rates are equivalent to the best in the world. In 2006–2010 in Australia, the five-year relative survival rate was 66 per cent for all cancers combined.⁴

This achievement reflects strong public awareness of prevention, screening and early detection messages, evidence-based clinical cancer guidelines and proven population screening programs.

Fundamental to these improvements is the high-quality work of health professionals in diagnosing and managing cancer, effective new therapeutics and treatments, and a health system that is designed to deliver accessible high quality treatment that is focused on the needs of the patients.

The primary care sector is vital to the cancer care workforce, as care must be planned and delivered across the continuum of care, from diagnosis to treatment, recovery and living with or after cancer.

In Tasmania, cancer services are currently delivered at all four of our major acute hospitals.

Table 1: Current Clinical Services Profile

	RHH	LGH	NWRH	Mersey
Medical Oncology	6	6	5	4
Radiation Oncology	6	6	No level	No level
Haematology	6	5	4	4

⁴ AIHW & AACR (2012). Cancer in Australia: An overview 2012. Canberra: AIHW.

The RHH and the LGH both have radiation treatment centres. These are supported by linear accelerators (LINACs), large machines necessary for the provision of radiotherapy services, which should be matched to community demand in the population they serve. There are two LINACs at RHH and three at the LGH.

The North West region does not have a local radiotherapy service. Patients from the North West region requiring radiotherapy services currently travel to the LGH, with a small number of patients travelling to Melbourne for specialist radiotherapy services.

Delivery of high quality cancer services is dependent on the availability of an integrated workforce to diagnose, plan and provide treatment.

There have been ongoing issues with the recruitment of staff to support oncology services in the North West. This will be exacerbated by the planned delivery of radiation oncology services locally in this region.

North West Regional Hospital has been unable to attract and retain medical oncologists. At present the North West has access to a 0.6 FTE medical oncologist who is a fly-in / fly-out doctor from the Peter MacCallum Cancer Centre in Melbourne. A change in the model of care in the North West is needed to improve the safety of the service due to the lack of availability of an on-call medical oncologist.

Developing Integrated Cancer Services

Access to high quality cancer services equipped to deliver services into the future depends on a service that is integrated across all regions, with standardised clinical processes, transparent accountability and oversight of a coordinated service to patients. Services need to be closely linked across the acute and primary sectors to deliver truly patient centred care.

Cancer services will be delivered through the Southern and Northern Integrated Cancer Services.

A Northern Integrated Cancer Service will be developed to deliver medical and radiation oncology services across the North and North West. The service will be managed from Launceston with service sites in the LGH and NWRH.

A Northern Integrated Cancer Service will enable the THS to commission the new LINAC at the NWRH using shared staff delivering services across the entire northern half of the state. This will be a safer and substantially more efficient option than replicating the failed regional model with an isolated, stand-alone North West cancer service which does not meet national standards.

The Way Forward

Development of the Integrated Cancer Services in partnership with the community and the Cancer Clinical Advisory Group

Through the maintenance of an integrated cancer service across the North and North West, patients in the North of the state will be able to benefit from a stable, sustainable cancer services workforce, services closer to home, and greater support within their local community. The improved use of telehealth, where appropriate, will allow for the planning, delivery and monitoring of care while minimising travel requirements.

Table 2: Proposed Clinical Services Profile

	Southern Integrated Cancer Centre		Northern Integrated Cancer Centre	
	RHH	LGH	NWRH	Mersey
Medical Oncology	6	6	5	(4)*
Radiation Oncology	6	6	5	No level
Haematology	6	5	4	4

*To be confirmed with the establishment of the integrated cancer services.

the patient journey

Now

Roseanne is a teacher in Wynyard, recently diagnosed with breast cancer. She initially had surgery at the NWRH. The next step in her treatment is radiotherapy, once a day, five days a week for five weeks. This is not available locally, which means Roseanne has to travel three hours a day to access the treatment, putting a strain on both her and her family when they are least able to cope with it.

One Health System

Following the development of a Northern Integrated Cancer Service that manages cancer services across the North and North West, a critical mass of staff working across the region enables the new linear accelerator to be commissioned for the North West.

Roseanne can now receive her radiation therapy at the NWRH, her daily travel for radiation treatment decreases to just 30 minutes, leaving her more time to spend with her family.

2.2.3 Trauma services

Trauma services provide for the immediate transport, assessment, stabilisation and management of patients presenting with trauma.

Table 1: Current clinical services profile

	RHH	LGH	NWRH	Mersey
Trauma	5/6	5	4	3

The RHH currently meets a number of criteria for a level 6 service or has access to particular service requirements through relationships with interstate trauma services.

There are some capabilities that are unsustainable at state level e.g. some pelvic fracture reconstructive surgery and some sub-specialty paediatric or neonatal trauma and burns. These will need referral to larger interstate centres.

This does not diminish the roles of the LGH and RHH as state tertiary referral centres for major trauma (levels 5 and 6 respectively), providing centralised and high quality consultant-led major trauma services.

A CAG has been established to provide advice on the optimal configuration of trauma services across the State. The Trauma and Burns CAG has made a number of recommendations relating to trauma services, including that a statewide trauma system should be established with clearly defined:

- management responsibilities and accountabilities including delegations
- logistic transport responsibilities and accountabilities, and
- clinical responsibilities and accountabilities.

The experience in other states is that providing the highest level of trauma care at fewer, but more specialised, centres leads to better outcomes, more efficient services and more effective integration with interstate partners.

It is proposed that there is a change to the clinical services profile to acknowledge formally the role of the RHH as a level 6 trauma service for the whole state, rather than only for the Southern population.

This means that the most serious trauma cases will receive treatment at the RHH. This will particularly benefit those patients requiring timely access to highly specialised services such as neurosurgery, cardiothoracic surgery, or high level critical care services.

The RHH will be the principal hospital for all major trauma cases across the state, with the capacity to receive inter-hospital transfer of major trauma patients from all other levels of care. The decision of Government to provide \$10.5 million for the installation of a helipad at the RHH as part of the current redevelopment provides the opportunity to further consider the role of aeromedical retrieval services in Tasmania.

By developing a single major trauma centre in the state, supported by an effective and responsive aeromedical and road retrieval service, we can provide Tasmanians the assurance that our trauma systems, practices and outcomes are consistent, high quality, integrated and supported across the state.

Table 2: Proposed clinical service profile

	RHH	LGH	NWRH	Mersey
Trauma	6	5	4	3

2.2.4 Critical care services

The current clinical service profiles for emergency and intensive care services have high complexity services delivered from the LGH and the RHH. Lower complexity services are delivered from both acute hospitals in the North West.

Table 1: Current clinical services profile

	RHH	LGH	NWRH	Mersey
Emergency	6	5	4	3 capability but some services provided at level 4 and above
ICU/HDU	6	5	4	Stand alone HDU*

*A stand alone HDU does not currently fit within the current TRDF

There have been ongoing issues in the provision of these services at the current levels in the North West. These issues centre on the safety and quality of the services, inefficient and duplicated services and difficulties in recruiting and retaining an appropriate workforce.

24 hour Emergency Department (ED) services are currently provided at the NWRH and the Mersey. Advice from clinicians indicates that the complexity of cases currently taken to the Mersey via ambulance is too high for the ED and associated support services available on site. Into the future it may no longer be necessary to have the Mersey ED open overnight other than for those requiring stabilisation for life threatening conditions prior to transfer.

The Intensive Care Unit (ICU) and High Dependency Unit (HDU) facilities in the North West region could be better utilised.

From 2009-2013, the North West Region had 43 per cent of the State's ICU admissions, but only 12 per cent of the patients in Tasmania requiring intubation and ventilation. This is a reflection that many patients currently being managed in ICU in the North West could be more appropriately managed in medical wards at significantly lower cost (up to \$1 600 less per night).

Greater support across the North and North West on safety and quality issues, including the selection of surgical cases and support for the inpatient wards will enable better use of ward beds and reduced use of ICUs.

Recruitment and retention of clinicians to the specialist-led model of care that currently operates at the Mersey ED has traditionally been difficult. There are high levels of locum use and this has a negative impact on the sustainability, quality and safety of the service that can be provided.

NWRH ICU is dependent on a single intensive care specialist consultant, supported by specialist anaesthetists. This introduces uncertainty to the viability and sustainability of the service. This is an unsustainable position in the longer term.

Table 2: Proposed Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Emergency	6	5	4	3
ICU/HDU	6	5	4	Short stay unit within ED for stabilisation

An examination of the model of care and staffing skills mix at the ED at the Mersey is necessary to ensure it better meets the needs of presenting patients. Service reconfiguration may improve the quality and safety of care and ensure the sustainability of the service, including being staffed sustainably. Whilst the level of this service will remain unchanged level 4 and 5 services will be provided at a higher level site. This includes the following changes to the operation:

- Patients with serious conditions picked up by ambulance will be transported directly to the NWRH or the LGH, with the possible exception of patients with acute chest pain. These patients, in whom early time critical intervention has been shown to be of benefit, may be stabilised at the Mersey prior to transfer.
- The workforce model that supports the ED service will change to improve the sustainability of the workforce and improve the quality and safety of the service. There may be merit in incorporating rural generalists with both general practice and emergency skills into the ED staffing model.
- With future service reconfiguration it is planned that over night demand for ED services will reduce to the point where a 16 hr ED service will be sufficient other than for those requiring stabilisation for life threatening conditions prior to transfer.

These changes to the ED at the Mersey will ensure that the local community will continue to be able to access urgent care when required, and that those requiring higher level care, particularly those likely to progress to an inpatient admission, will receive care at one of the larger EDs in NWRH or LGH. This will improve waiting times for those accessing the lower acuity services at the Mersey, and ensure that those requiring higher level care will be able to access the necessary support services in the larger centres.

The current HDU at the Mersey will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre.

To support a more sustainable service, intensive care services at the NWRH will continue to be provided at level 4 for patients presenting with emergency situations.

As recommended by the key critical care clinicians and the ED CAG, these changes need to be supported by appropriate acute and non-urgent transport arrangements. These include:

- A clear Tasmanian ambulance destination policy that is well communicated to and understood by the public. This describes which hospital the patient will be transported to in certain circumstances.

Changes to destination hospitals may result in ambulances and their crews having longer travel times. It may also result in fewer occasions of transport. This will be the subject of further analysis and consultation prior to the release of the White Paper.

- This policy should reflect the role delineation of the hospitals. Patients should not be transported to any hospital that does not have the capacity to manage them and their condition. This will reduce subsequent inter-hospital transfers and the associated decrease in safety.
- A transport system for the patient and their family so that after their acute care is provided at a non-local hospital they are able to return to their local area in a timely fashion and at a reasonable cost.
- An accommodation system that supports patients and their families if they are discharged from a non-local hospital but, for whatever reason, are unable to travel home immediately.
- An enhanced bus/other transport service so that the families can visit their in-hospital relative easily. This is extremely important in the North West as travelling out of area is a significant financial burden.

the patient journey

Now

Lauren is attending the Mural Fest in Sheffield but stumbles when stepping onto the road. She falls awkwardly and suffers a compound fracture of her left ankle.

Lauren is taken by ambulance to the closest hospital, the Mersey, where she is stabilised. The Mersey is not able to provide the complex orthopaedic surgery she requires, the ambulance service is busy and she waits a further four hours in the emergency department prior to being transferred to the LGH. By this stage it is late evening and there is no capacity to undertake the surgery until the following morning.

One Health System

The paramedics recognise that Lauren has a compound fracture and transfer her directly to the LGH in accordance with the new Ambulance Destination Policy. Emergency surgery is arranged that afternoon.

2.2.5 Subacute care services

Subacute care includes rehabilitation, geriatric evaluation and management (GEM), psychogeriatric care and palliative care.

In Tasmania, hospitalisation rates for people aged 65 years and over are increasing faster than other age groups.

Subacute care is provided to a broad range of medical and rehabilitation patients to enable them to improve their health and wellbeing maximise their function and maintain their independence.

The majority of subacute care in Tasmania is for rehabilitation (76 per cent). The primary reasons for admission are stroke and musculoskeletal conditions (fractures, joint replacements). The North has a total of 38 dedicated rehabilitation beds, while the South with a similar population has 62 beds. There have been ongoing difficulties in recruiting and maintaining a workforce in this area. Both public and private hospitals provide inpatient subacute care. Sub-acute care is responsible for 8.1 per cent of all public hospital and 8.2 per cent of private hospital bed days in Tasmania. However, GEM and psychogeriatric care are largely provided in public hospitals.

In Tasmania, particularly in the North West, subacute care services availability is below the national average:

- In Tasmania 1.8 per cent of all hospital admissions are for subacute care compared with 2.9 per cent nationally.
- This, combined with Tasmania's lower overall hospitalisation rates, results in markedly reduced (50 per cent less) subacute care activity in Tasmania when compared nationally. Subacute inpatient care in Tasmania results in 3.4 public hospital separations per 1 000 head of population compared with a national average of 7 per 1 000 head of population.

Most Tasmanian inpatient subacute care is provided in the South. Between 2007-08 and 2011-12, of a total 52 476 bed days, most subacute bed days were at the RHH (25 109 days) or private hospitals (15 893 day), followed by the LGH (7 555 days).

With regard to palliative care beds, there are no beds in the North West region.

Table 1: Current Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Geriatrics	6	5	3	No level
Rehabilitation	5*	5	3	No level
Palliative care	4**	4**	4**	No level

* level 6 service provided interstate

** Palliative Care service level determined by the National Palliative Care Role Delineation Framework

Table 2: Proposed Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Geriatrics	6	5	3	4
Rehabilitation	5*	5	3	4
Paliative care	4**	4***	3	3

* Level 6 service provided interstate

** Palliative Care service level determined by the National Palliative Care Role Delineation Framework

*** Services purchased from private sector

The proposed clinical service profile substantially increases subacute service delivery in the North West and in the North by utilising the Mersey to deliver better subacute care. This will provide a greater level of access to nurse-led subacute services in the Mersey's local community, supported by specialist medical practitioners in the North and South, which can also be accessed by patients and consumers in the South, North and broader North West. It is proposed that there will be overnight subacute services and care delivered by nurse-led multidisciplinary teams.

the patient journey

Now

Warwick is 86 years old and lives in an independent living unit in Port Sorell. He has a fall at home and breaks his hip, requiring a hip replacement.

Warwick has his surgery at the NWRH. He has a slow recovery and there are no inpatient rehabilitation services available. He is transferred to a nursing home facility where he can continue to receive nursing care. Warwick never regains the condition necessary to become independent again.

One Health System

Warwick has his surgery at the NWRH and the following day is transferred to the rehabilitation service at the Mersey.

He spends a month under the care of this multidisciplinary service and is able to go back to living independently in the community.

2.2.6 Maternity and neonatal services

Maternity and neonatal services are provided in the four major acute hospitals as well as a number of rural hospital sites.

Maternity services

Current models of care provided in Tasmania include:

- Obstetric led care
- GP and obstetrician team-based shared care, and
- Midwifery led care where midwives are the main carers, providing antenatal services in hospital based or outreach clinics and delivery care in conjunction with an obstetric team.

Table 1: Current Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Maternity Services	6	5	4	4

Maternity services in the North West are currently provided at the Mersey and at the NWRH via a private provider. Approximately three quarters of these births occur at the North West Private Hospital.

There have been numerous reviews of maternity services in the North West. All of these reviews have identified a need to change the way that the services are delivered. These recommendations are based on:

- poor safety of the existing service model
- ongoing recruitment difficulties that have necessitated long-term use of locum obstetric staff at the Mersey, and
- suboptimal clinical outcomes.

The delivery of maternity services in the North West continues to be fragmented and there are significant safety challenges in delivering the service. This includes ongoing difficulty in recruiting consultant obstetric staff and on-call paediatric support being provided from Burnie after hours.

Maternity services in the North West will continue at level 4 complexity; however these services will be consolidated to one site at either the NWRH or the Mersey in order to improve the safety and quality of the services for all women and their families.

There are complexities in the current way that services are delivered in the North West, including a private contracted model at the NWRH and ongoing negotiations with the Australian Government in relation to the Mersey Community Hospital, that will have to be considered before a final decision can be made on the profile of maternity services in the North West region.

Table 2: Proposed Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Maternity Services	6	5	(4)*	(4)*

(*) = A level 4 service at one of these two sites.

Neonatal services

Neonatology Services provide a range of care from well infant care to highly specialised care, for sick, low birth weight and/or premature infants, and/or infants born with congenital or other conditions.

Table 1: Current Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Neonatal Services	6	5	4	3

There is a *National Capability Framework for Maternity Services* that outlines service capability for neonatology.

In order to bring Tasmania in line with this framework, the current levels of service would not need to change, however there does need to be a change in the gestational age at which the different services institute a transfer policy.

This would mean:

- The LGH will provide care to infants greater than or equal to 32 weeks gestational age. There is no neonatologist so infants at lesser gestational ages will be transferred to the RHH
- The North West will provide care to infants greater than or equal to 34 weeks at the single level 4 maternity service, the site of which is yet to be determined (see above).

Compelling data was provided as a result of the public consultation process for the Green Paper that suggests outcomes for babies born at less than 28 weeks gestation and managed within Tasmania are not as good as interstate outcomes of large neonatology services. This has signalled a need to determine the best service model for care of neonates less than 28 weeks gestation in Tasmania.

We will work with clinicians, consumers and other stakeholders to further explore this issue and determine a final service model, including a decision on where best to provide care for neonates with a gestational age less than 28 weeks.

Table 2: Proposed Clinical Service Profile

	RHH	LGH	NWRH	Mersey
Neonatal Services	6	5	(4)*	(4)*

(*) = A level 4 service at one of these two sites.

2.2.7 Burns services

The service model for burns management in Tasmania has been referred to the Tasmanian statewide surgical services committee (TSSSC) for consideration.

The TSSSC have been asked for advice regarding optimal service configuration for burns as there are relatively low volumes of patients with burns in Tasmania, particularly patients with large and / or complex burns. Since 2006, only 39 patients with burns greater than 29 per cent body surface area have been treated in Tasmania.

Burns are currently being treated at all four of the acute hospitals. Northern and Southern Tasmania both have highly developed plastics and reconstructive surgical services able to manage less complex burns. The North West hospitals do not have these necessary support services available.

The RHH also has a well-established burns unit. The sustainability of continuing to provide a burns unit locally, on a background of decreasing volumes of burns being treated in specialist units throughout Australia and internationally, requires review of the current service model. This will include consideration of the support of interstate burns services in providing specialist burns care to severely injured Tasmanian patients.

The identified upper threshold for the transfer of patients to interstate facilities (if at all) is yet to be determined.

There is also national work being undertaken on transfer policies.

The TSSSC will continue to consider this issue and provide further advice.

2.3 Clinical service profile changes for the acute care system

It is important that health services are considered in the context of the statewide system, and not merely on the basis of the facilities where they are delivered. To assist in explaining the implications of the proposed changes to service profiles, it is helpful to detail how the changes impact on the service provided at each of the four major acute hospitals.

The following section outlines the major changes proposed in the services profile of the LGH, Mersey, NWRH and RHH. Some changes relate to the level of services provided, others to the changes required to align existing services to the role delineation framework.

2.3.1 Launceston General Hospital

The LGH provides a broad range of services. More than a quarter of the patients treated by the LGH live in the North West. The LGH has a longer length of stay and a lower bed occupancy rate when compared to similar sized hospitals elsewhere in Australia. It has a higher proportion of surgical patients, with a breadth of services that is comparable to similar hospitals. Renal dialysis accounts for almost a third of admitted patients, although this includes satellite services provided to patients in the North West.⁵

The LGH will continue to be the principal referral hospital for the North and North West of Tasmania, and will provide a number of tertiary services. Greater attention will be given to using the services and expertise at the LGH to support quality services across the North and North West.

Proposed changes to the service profile of the LGH are outlined below. Improving service delivery will be linked to increased efficiencies in the delivery of health services across the entire system. This will bring the dual benefits of enabling more episodes of service to be provided, and assisting in ensuring the safety and quality of services for the North and North West.

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Service	Current Service Profile	Proposed Service Profile	Benefits
Cancer services	The LGH currently provides level 6 cancer services across medical oncology and radiation oncology, and level 5 haematology services. These services are accessed by many people from the North West.	The Northern Integrated Cancer Service will deliver medical oncology and radiation oncology services for North of the state including the North West. The level of services will remain the same, with the population of Northern Tasmania benefitting from greater integration of services. The service will be based and managed from the LGH with service sites in LGH and the NWRH.	Greater access to Cancer services will be available across the North West. The proposed model will enable the THS to commission and operate the new Linear Accelerator at the NWRH using a shared staff service delivery model across the entire North of the state. This overcomes the sustainability issues in relation to having a critical mass of staffing. This will be a safer and substantially more sustainable service.
Endocrinology	The LGH currently provides a level 4 endocrinology service. This includes inpatient and outpatient care by an endocrinologist or general physician with dual training in endocrinology.	This service will be increased to a level 5 service to include a regional referral role.	People in the North and North West of Tasmania have similar rates of diabetes- this service profile change will provide better access to specialist endocrinology services. This increased service level will assist people in the North and North West to access better endocrinology care, preventing long-term complications and empowering patients to manage their disease in their homes and in their communities.
Infectious diseases	The LGH currently provides a level 4 infectious disease service which includes ambulatory and inpatient consulting by an infectious diseases physician and a visiting sexual health service by a sexual health physician located in Hobart.	This service will be increased in complexity from level 4 to level 5 to provide a broader range of services.	There are sufficient volumes to support two sexual health physicians in Tasmania (there is currently one). By operating from the LGH, a second sexual health physician will provide services for people in North and North West Tasmania and allow the service to become a level 5.

Service	Current Service Profile	Proposed Service Profile	Benefits
Neurology services	The LGH currently provides a level 4 neurology service including inpatient care by an on-site physician practicing in general medicine and outpatient consultation by a visiting neurologist.	This service will be increased to level 5 to provide increased inpatient and outpatient specialist neurology services. This service will carry responsibility for meeting need across the North and North West.	People in the North and North West with neurological conditions will have shorter waiting times to access specialist services, which will lead to improved outcomes.
Respiratory medicine	The LGH currently provides a level 4 respiratory service.	This service will be increased to level 5 to provide additional respiratory function assessment capability.	People in the North and North West have substantial respiratory disease burden. They will have shorter travel times to access more highly specialised respiratory services.
Rheumatology and pain management	The LGH currently provides a level 4 rheumatology and pain management service. This service is ambulatory and is provided by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology and pain management services.	This service will be increased to level 5.	People in the North and North West with rheumatological conditions have poorer access to specialist rheumatology services compared to people in the South. In addition, there are fewer specialist pain services available to people in the North and North West compared with the South. This change will improve access to specialist treatments for rheumatological and pain conditions for people in North and North West Tasmania.
Surgical services (cont. over)	The LGH currently provides high complexity sub-specialist surgical services across a broad range of disciplines.	An integrated northern surgical service managed from the LGH and operating across the North and North West is created to increase access to specialist services in the North West, and reduce the disparity in costs between the NWRH, Mersey and LGH. The optimal management of patients with extensive burns and complex head and neck surgery is currently being reviewed.	Consolidating some highly complex surgical services that are currently provided at low volumes in multiple sites will improve the efficiency and safety of those services and make them more sustainable into the future. Quality monitoring systems will be developed in conjunction with clinicians to identify additional areas where quality improvements can be made.

Service	Current Service Profile	Proposed Service Profile	Benefits
Surgical services (cont.)		It is proposed that high complexity upper gastrointestinal surgical services are provided through a single site in order to improve the efficiency and sustainability of care delivered to patients requiring these services. Options for the consolidation of these services include the RHH or the LGH and are being considered in consultation with the Tasmanian Statewide Surgical Services Committee (TSSSC). There are significant benefits to consolidating this service in Launceston, however service complexities need to be assessed before a final decision is made.	
Oral health services	The LGH currently provides a level 3 oral health service which includes general community dental services by registered dentists.	Increase to level 4.	<p>The increase in level would address the limited access to theatre time in the state.</p> <p>In turn, this would address the considerable inequity between regions in terms of waiting times and types of care provided.</p> <p>The increase in level would also support the development of increased service access across the North West.</p>
Neonatology services	The LGH currently provides a level 5 neonatology service and has the capability to plan and deliver care for infants with risk factors or complex care needs who were born at the hospital or back transferred from a higher level service and who are greater than or equal to 32 weeks gestation.	This service will remain at level 5.	<p>Babies born at 30 and 31 weeks will receive care at the RHH.</p> <p>This will ensure there are greater support services available for these babies if their care needs become more complex.</p>

Service	Current Service Profile	Proposed Service Profile	Benefits
Mental health inpatient services	<p>The LGH currently provides a level 5 inpatient mental health services.</p>	<p>This service will remain at level 5.</p> <p>Acute mental health inpatient services will continue to be provided at the LGH. LGH specialists will deliver increased services to residents of the North and North West at the Mersey. Enhanced subacute mental health service capability will be provided to residents of the North and North West through the development of subacute mental health services, including psychogeriatric services, at the Mersey site.</p>	<p>There is significant regional variation in inpatient service provision for people receiving mental health treatment.</p> <p>The development of enhanced subacute services at the Mersey will mean people in the North and North West who require subacute services have comparable access to their Southern counterparts.</p>
Child and adolescent mental health inpatient services	<p>Currently a level 3 service.</p>	<p>This service will increase to level 5 and will provide inpatient services for residents of the North and North West.</p>	<p>Tasmania lacks sufficient child and adolescent mental health services to meet current demands. This change will increase the availability of inpatient services locally for residents of the North and North West.</p>
Geriatric services	<p>The LGH currently provides a level 4 geriatric service which provides inpatient care by a specialist geriatrician and physicians practicing in general medicine.</p>	<p>This service will be increased to level 5.</p> <p>Acute geriatrics services will be delivered at the LGH and across the North West.</p> <p>Enhanced subacute geriatrics service capability will be provided to residents of the North and North West through the development of subacute geriatric services at the Mersey site.</p>	<p>This change will enable patients in the North West to have greater access to specialist geriatricians. It will also enable the establishment of nurse-led subacute geriatrics services at the Mersey.</p> <p>The development of enhanced subacute services at the Mersey will mean people in the North and North West who require subacute services have comparable access to their Southern counterparts.</p>

2.3.2 North West Regional Hospital

The NWRH has a very high proportion of surgical patients and a much broader case mix than similar hospitals interstate. Despite the relatively close presence of the Mersey and the LGH, when compared with similar hospitals, the NWRH has concentrated on a case mix more complex and more oriented towards patients requiring admission for more than one day. It also has a longer length of stay than comparable facilities.⁶

The NWRH will continue to be one of two acute hospital campuses in the North West delivering general hospital services.

There are a number of changes that are recommended through the development of the clinical services profile that will enable the NWRH to strengthen its role in providing general hospital services to its local community, while also moving the management and delivery of some more complex services to the LGH, RHH or interstate to improve both the efficiency and quality of those services.

Changes to service profile of the NWRH include:

Service	Current Service Profile	Proposed Service Profile	Benefits
Intensive care services	The NWRH currently provides intensive care services at level 4. This includes the capability to provide immediate resuscitation, short term cardiorespiratory support and mechanical ventilation.	This service will remain at level 4. The NWRH will provide level 4 ICU services. However, patients who require ICU admission as a result of an elective procedure or who require prolonged ventilation will receive their care at a higher level site.	The service change will assist in addressing the challenges of utilising the ICU/HDU service with low rates of mechanical ventilation and shorter lengths of stay, which suggests that the patients are generally of a lower acuity. It will also help to address the single person dependency, by clarifying the role of the ICU across the NWRH and the Mersey supported by anaesthetic staff.
General medicine	The NWRH currently provides a level 5 general medicine service which includes the provision of inpatient care by a general medicine physician, supported by inpatient and outpatient consultations for a (limited) range of medicine subspecialties.	This service will remain at level 5.	General medical services in the North West will be consolidated to the NWRH.

⁶ Report of the Commission on Delivery of Health Services in Tasmania - April 2014

Service	Current Service Profile	Proposed Service Profile	Benefits
Cancer services	<p>The NWRH currently provides:</p> <ul style="list-style-type: none"> – level 5 Medical Oncology – level 4 Haematology – N/A Radiation Oncology 	<p>A Northern integrated cancer service will be established that will administer integrated cancer services across the North and North West, managed from the LGH.</p> <p>Upon commissioning of the LINAC at the NWRH, there will be a level 5 radiation oncology service at the NWRH.</p>	<p>Ongoing workforce sustainability issues result in service gaps in the North West.</p> <p>Workforce planning, recruitment and retention by LGH on behalf of the North and North West will improve the sustainability of the cancer services clinical model in North West Tasmania.</p> <p>The establishment of a Northern integrated Cancer Service will assist in closing the gap and will enable the THS to commission the new LINAC at the NWRH using shared staff delivering services across the entire North of the State.</p>
Neurology services	<p>The NWRH currently provides a level 3 neurology service including inpatient care by an on-site general medicine physician and outpatient consultation by a visiting neurologist.</p>	<p>This service will increase to level 4.</p> <p>Higher level services will provide increased visiting specialist neurology services to the NWRH.</p>	<p>People in the North West who have neurological conditions, particularly those with multiple sclerosis and motor neuron disease, will have shorter waiting times to access specialist services, with a consequent improvement in outcomes.</p>
Acute stroke services	<p>The NWRH currently provides a level 4 service.</p>	<p>This service will remain at level 4, however consolidation of acute stroke services at the Mersey and NWRH to the NWRH site will increase the volume of stroke patients treated at the NWRH and will enable increased staff skills development. Patients after their stroke will have access to highly developed subacute stroke services at the Mersey.</p>	<p>Both the NWRH and the Mersey treat small volumes of patients with stroke. By consolidating services at the NWRH and by establishing increased subacute service capability (rehabilitation services) at the Mersey, service quality can be improved overall.</p>

Service	Current Service Profile	Proposed Service Profile	Benefits
Rheumatology and pain management	N/A	<p>This service will be established at level 4.</p> <p>Higher level facilities will provide visiting specialist rheumatology and pain management services.</p> <p>This service would be provided on an outpatient basis by a multidisciplinary team, led by a specialist medical practitioner with subspecialty training in rheumatology and pain management services.</p> <p>The service will be supported through telehealth.</p>	<p>People in the North and North West with rheumatological conditions have poorer access to specialist rheumatology services compared with people in the South. In addition, there are fewer specialist pain services available to people in the North and North West compared with the South.</p> <p>This change will improve access to specialist treatments for rheumatological and pain conditions for people in North and North West Tasmania.</p>
Surgical services	The NWRH currently provides some general surgical services at level 5 and 6, but only has the service capability to safely provide on-site high complexity services to level 4.	<p>High complexity surgery will be provided at other facilities within the THS and will no longer be performed on-site.</p> <p>The NWRH will continue to provide on-site and on-call low and moderate complexity surgical services.</p> <p>Visiting specialists from higher level services will increase the delivery of subspecialist pre- and post-operative surgical care to people in the North West. This includes a new urology service in the NWRH and the Mersey.</p>	<p>These changes will increase access to subspecialist surgeons for people in the North West.</p> <p>It will also ensure that there is an adequate volume of surgery to maintain the safety and quality of local surgical services.</p> <p>Residents will still have access to on-site ENT and orthopaedics.</p> <p>Patients requiring more complex surgery or complex care will travel to the LGH, RHH or interstate.</p>
Gynaecology services	The NWRH currently provides a level 4 gynaecology service which includes the provision of a diagnostic service and surgery by specialist gynaecologists	This service remains level 4.	Inpatient services for the North West will be consolidated at the NWRH.

Service	Current Service Profile	Proposed Service Profile	Benefits
Neonatology services	The NWRH currently provides a level 4 neonatology service which includes the capacity to plan and deliver care to infants greater than or equal to 34 weeks.	A single site North West service will be provided that will remain at level 4.	A single site maternity service will be established in the North West at a site to be determined. The site will provide care for babies born at 34 weeks gestation or greater.
Maternity services	The NWRH currently provides level 4 maternity services.	Maternity services in the North West will be re-configured to improve their safety. There will be one level 4 maternity service provided in the North West. The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the most appropriate location for this service.	The North West currently has a higher rate of pregnancy complications than the other regions. Consolidating services to a single site will improve the safety, quality and sustainability of maternity services in the North West.
Drug and alcohol services	The NWRH currently provides a level 3 drug and alcohol service which includes inpatient and outpatient detoxification and support services for low risk patients.	This service will remain at level 3.	Although the service level remains the same, the level of resource NWRH directs to drug and alcohol services will need to increase to enable it to function as a level 3 service. This will enable a more effectively consolidated service to address particular alcohol and drug issues facing the North West.
Geriatric services	The NWRH currently provides a level 3 geriatric service.	This service will remain at level 3.	Enhanced subacute geriatrics service capability will be available to residents of the North and North West through the development of subacute geriatric services at the Mersey site.
Rehabilitation medicine services	The NWRH currently provides rehabilitation services at level 3 providing interdisciplinary care for functional restoration in patients following an episode of disability.	This service will remain at level 3.	Enhanced subacute specialist rehabilitation service capability may be provided to residents of the North and North West through the development of subacute rehabilitation services at the Mersey site.

2.3.3 The Mersey Community Hospital

The Australian Government has owned and funded the Mersey since 2008. There is an agreement with the Tasmanian Government that the Mersey is to operate as part of the broader Tasmanian health and hospital system.

The ongoing management, operation and funding of the Mersey is governed by the current Heads of Agreement, which expires on 30 June 2015. Negotiations regarding the future arrangements for the Mersey between the Australian and Tasmanian Governments are underway, with both governments publicly committing to working together to agree on a sustainable long term solution for the ownership, management and funding of the Mersey.

The Mersey will continue to operate as one of two acute public hospital campuses in the North West.

The Mersey currently transfers a significant proportion of patients to the NWRH and the LGH. For example, over 55 per cent of non-admitted ED presentations who were not discharged home were transferred somewhere else, with most going to the NWRH and LGH.

The changes to the service profile of the Mersey, as outlined below, will result in increased access to subacute care services in the North West, such as mental health, rehabilitation and geriatric care. This has been a significant service gap in the North and North West.

Changes will also contribute to reducing the delivery of high complexity, low volume services locally in order to improve patient safety and service quality. This will assist in establishing and maintaining sustainable and appropriate services that are responsive and accessible for the local community, as well as enabling these high complexity services to be concentrated in other facilities, where greater volumes of service will lead to both increased safety and improved efficiency.

Importantly, establishing an Elective Day Surgery Centre at the Mersey has the potential to benefit patients from around the State as it will increase capacity to provide timely access to elective surgery and ensure there is a capacity to sustainably meet the growth required in services required in the future.

Changes to service profile of the Mersey include:

Service	Current Service Profile	Proposed Service Profile	Benefits
High dependency unit (HDU)	The Mersey currently provides HDU services.	The current HDU at the Mersey will be changed to a short stay unit. This area will be used when critically ill or injured patients require stabilisation prior to transfer to a larger centre.	<p>An average of only six patients a year over the past six years have required urgent ventilation.</p> <p>With these volumes, critically ill and injured patients are more safely and efficiently managed at a higher level facility.</p> <p>A short stay unit will be better equipped to stabilise and prepare patients for transfer.</p>

Service	Current Service Profile	Proposed Service Profile	Benefits
Emergency medicine	The Mersey currently provides a level 3 emergency medicine service.	This will remain a level 3 service.	<p>The model of care and staffing skills mix at the ED will be enhanced to better meet the needs of presenting patients and improve the quality and safety of care.</p> <p>Patients with serious conditions picked up by ambulance will be transported directly to the NWRH or the LGH with the exception of patients with acute chest pain who will be stabilised prior to transfer.</p> <p>Increased workforce support will occur through the introduction of 'rural generalists' (physicians with both general practice and emergency skills) into the ED.</p>
Cancer services	The Mersey currently provides cancer services at level 4 which includes visiting oncology services with well-trained registered nurses with specialist cancer care knowledge and expertise, including in the administration of ambulatory chemotherapy to patients.	The Mersey, like the NWRH, will contribute to and benefit from the Northern Integrated Cancer Service.	The Northern Integrated Cancer Service will provide cancer services, including decisions on the role of the Mersey in day treatments.
Acute stroke services	The Mersey currently provides a level 4 service.	This will be changed to a level 3 service.	Both the NWRH and the Mersey treat small volumes of patients with stroke. By consolidating services at the NWRH and by establishing increased subacute service capability (rehabilitation services) at the Mersey, service quality can be improved overall.

Service	Current Service Profile	Proposed Service Profile	Benefits
Surgical services	The Mersey currently provides some general surgical services at level 5 and 6, but is predominantly providing services to level 4.	<p>The level of complexity for these services will be changed to level 3.</p> <p>An Elective Day Surgery Centre will be established at the Mersey.</p> <p>Subspecialist surgical providers from LGH (and potentially RHH for some disciplines) will provide increased access to subspecialty surgery for the people of the North West of Tasmania. This includes a new urology service in the NWRH and the Mersey.</p>	<p>No emergency surgical services or overnight elective surgical services will be provided at the Mersey. Patients requiring emergency surgery, complex surgery or overnight elective surgery of any type will travel to a higher level service.</p> <p>This has the potential to benefit patients from around the State by increasing capacity to provide timely access to elective day surgery. This will also ensure there is a capacity to sustainably meet the growth required in services required in the future.</p> <p>At the same time, the safety and quality of urgent surgical procedures and more complex surgical procedures will be improved with those services moving to sites with a greater volume of services.</p>
Gynaecological services	The Mersey currently provides gynaecological services at level 4 and includes some major procedures on low and moderate risk patients performed by visiting gynaecologists. However, the facility is only equipped to a level 3 capability.	<p>This service will be changed to level 3.</p> <p>Low complexity, same-day gynaecological services will be provided at the Mersey.</p>	<p>Overnight gynaecological services will be consolidated to the NWRH.</p> <p>This will enable greater access for low complexity procedures for local community residents, as well as providing a safer, more efficient consolidated service at the NWRH.</p>
Neonatology services	The Mersey currently provides a level 3 neonatology service which includes the capacity to plan and deliver care to infants greater than or equal to 37 weeks.	A single site North West service will be provided that will be at level 4.	A single site maternity service will be established in the North West at a site to be determined. The site will provide care for babies born at 34 weeks gestation or greater.

Service	Current Service Profile	Proposed Service Profile	Benefits
Maternity services	The Mersey currently provides maternity services at level 4.	<p>Maternity services in the North West will be re-configured to improve their safety.</p> <p>There will be one level 4 maternity service provided in the North West.</p> <p>The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the most appropriate location for service.</p>	<p>The NW currently has a higher rate of pregnancy complications than the other regions.</p> <p>Consolidating services to a single site will improve the safety, quality and sustainability of maternity services in the North West.</p>
Drug and alcohol services	No level at present.	Increase to level 4.	Establishment of mental health services enables on-site, colocated drug and alcohol services to be provided to residents of the North and North West of Tasmania.
Geriatrics	There is no geriatric service provided at the Mersey.	<p>Level 4 Geriatric services across the North and North West.</p> <p>The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.</p>	<p>The North and North West has significantly fewer specialist geriatric resources than the South.</p> <p>These services could be provided locally, reducing the need for patients, their families and carers to travel.</p>
Palliative care services	There is no palliative care service provided at the Mersey.	<p>We will investigate the feasibility of a level 3 palliative care service.</p> <p>The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.</p>	There no palliative care beds in the North West.
Rehabilitation services	There is no rehabilitation service provided at the Mersey.	<p>We will investigate the feasibility of a level 4 rehabilitation service across the North and North West.</p> <p>The DHHS will work with clinicians, the Australian Government (owner of the Mersey) and consumers to determine the best service model to meet community need.</p>	<p>The North and North West have fewer dedicated rehabilitation beds than the South for the same population size.</p> <p>These services could be provided locally, reducing the need for patients, their families and carers to travel.</p>

2.3.4 Royal Hobart Hospital

The RHH is the largest public hospital in Tasmania and provides a broad range of services.

Many of the services provided at the RHH are at a lower volume than comparable facilities on the mainland. This means these services are often expensive and in some cases not sustainable or clinically appropriate.

The RHH has a higher proportion of surgical patients, and its average costs per case is high compared to similar hospitals. The proportion of subacute patients is also high.

The RHH will continue to be the principal referral hospital for the South and will also provide a number of tertiary services for the state, including neurosurgery, cardiothoracic surgery and vascular surgery. The profile of the tertiary services provided on a statewide basis will be consistent with the final TRDF.

Changes to service profile of the RHH include:

Service	Current Service Profile	Proposed Service Profile	Benefits
Trauma services	<p>The RHH currently meets a number of criteria for a level 6 trauma service.</p> <p>This is the full spectrum of care for the most critically injured patients, from initial reception and resuscitation through discharge and rehabilitation.</p>	<p>A feasibility study will be undertaken to determine the infrastructure requirements for the RHH to maintain a level 6 service for the State.</p>	<p>Although RHH will maintain a level 6 trauma service the capacity of this service to support statewide access to time-critical treatment will be enhanced.</p>
Respiratory medicine	<p>The RHH is currently a level 5 service.</p>	<p>This will be increased to level 6.</p>	<p>The South is currently under-resourced for sleep medicine compared with the North / North West.</p> <p>Contemporary specialist respiratory services include the provision of a complete range of diagnostic services and highly developed bronchoscopy and sleep services.</p> <p>The level 6 service at the RHH will enable high complexity respiratory services to be delivered to patients in Tasmania, reducing the need for interstate travel. The level 6 service will establish statewide protocols to improve management of respiratory conditions.</p>

Service	Current Service Profile	Proposed Service Profile	Benefits
<p>Surgical services</p>	<p>The RHH currently provides high complexity sub-specialist surgical services across a broad range of disciplines.</p> <p>The RHH will continue to provide statewide cardiothoracic, neurosurgical and vascular surgical services.</p>	<p>The optimal management of patients with extensive burns is currently being reviewed.</p> <p>The optimal service configuration for providing some low volume surgical oncology services, particularly complex head and neck surgery is yet to be determined.</p> <p>It is proposed that high complexity upper gastrointestinal surgical services are provided through a single site in order to improve the efficiency and sustainability of care delivered to patients requiring these services. Options for the consolidation of these services include the RHH or the LGH and are being considered in consultation with the Tasmanian Statewide Surgical Services Committee (TSSSC). There are significant benefits to consolidating this service in Launceston, however service complexities need to be assessed before a final decision is made.</p>	<p>Some highly-complex surgical services are provided at low volumes in Tasmania. The safety and sustainability of these services needs to be optimised.</p> <p>Quality monitoring systems will be developed in conjunction with clinicians to identify additional areas where quality improvements can be made.</p>
<p>Child and adolescent mental health</p>	<p>The RHH is currently a level 4 service.</p>	<p>This will be increased to level 5.</p>	<p>An adolescent unit will be established as part of the redevelopment of the RHH. This unit will have the capacity to provide inpatient mental health services to adolescents in an appropriate environment.</p> <p>The level 5 service will establish a statewide model of care for the delivery of psychiatric services to child and adolescent patients and their families and carers.</p>

Tasmanian hospitals care for approximately 150 people a year who have a deep vein thrombosis after surgery. The estimated cost of caring for these people is \$940 000 in bed days alone. In a community model of care this cost could be reduced by \$790 000.

Tasmanian Medicare Local

2.4 Strengthening our primary care system and linkages

Tasmania needs a primary health system that is flexible and innovative, with the capacity to respond to new challenges in new ways as the roles of the acute hospitals shift. This will require a new way of thinking about how the whole health system is organised, valued, measured and reported.

As our reforms progress into the primary sector and the community we will be moving the system toward sustainability and achieving our vision of having the healthiest population in Australia by 2025.

Improving the coordination, collaboration with and integration of primary and community health with our acute services will significantly improve the maintenance of health of Tasmanians with chronic and complex conditions that will drive a cycle of efficiency. Through maintaining the health of those with chronic and complex conditions in the community, the overall costs of the system can be reduced, enabling more resources to be targeted to health improvement and maintenance.

Investments in preventive health and improving health literacy are also vital links in improving health outcomes.

Tasmanians' responses to the Green Paper have expressed clear expectations that health care services should

- be person-centred
- be outcomes-focused
- embody fairness and consistency across all activities, statewide
- recognise and involve community members in improving health outcomes
- acknowledge the life risks of poor health, especially literacy
- be informed and guided by comprehensive data collection and reporting systems that measure performance across a range of domains of value
- prioritise the most vulnerable in the community
- improve and integrate transport systems with clinical service delivery
- partner effectively across all sectors to achieve improved health outcomes, and
- provide a coherent "patient journey" by having effective linkages and communication processes in place.

Following the determination of the clinical service profiles, the contours of both the hospital sector and the primary health sector will continue to evolve as changes in service profiles impact upon the rest of the health system, including service types, service access points and patient travel needs.

2.4.1 The importance of preventative health and improving health literacy

The importance of prevention and early intervention in achieving a healthier Tasmania should not be underestimated.

It is well established that on many key indicators our population is less healthy and more exposed to chronic disease than populations elsewhere around Australia.

Importantly:

- 21.7 per cent of Tasmanians smoke, compared to 18 per cent nationally
- 69.4 per cent of Tasmanians are physically inactive, compared to 67.5 per cent nationally
- 65.6 per cent of Tasmanians are now overweight or obese, compared with 63.9 per cent five years ago, and
- 39.4 per cent of Tasmanians have high cholesterol – compared to 32.8 per cent nationally.

A new preventative health policy, *A Healthy Tasmania*, has been developed and the health system will be actively working with our partners in primary health and the community sector to progress this.

Delivering improvements in preventative health will work in conjunction with our reforms of clinical services to take pressure off hospitals and deliver better health outcomes for Tasmanians.

A key feature is a focus on improving health literacy. We know that low health literacy results in a wide range of problems and challenges for the health system, individuals, and families.

People with strong health literacy can make informed and appropriate health decisions, and better manage their own health. This means better patient outcomes and more effective use of health resources.

2.4.2 The importance of primary care in delivering better health outcomes for the community

Most health care occurs outside hospitals: in GP rooms, community health centres, private clinics, and in the home.

The activities that occur in the primary/community sector impact upon the kinds and levels of demand experienced by the acute sector, as people present for care in better or worse shape, for shorter or longer durations, and with more or less likelihood of re-presenting, depending upon the support available in the primary/community health sector. The roots of, and solutions to, many problems that are currently manifesting in hospitals actually lie in the community and primary health sector.

The current Health Pathways project with the TML is an example of how such a partnership can work. It has produced tools and strategies that support all practicing clinicians to provide person-centred care that keeps people out of hospital and Emergency Departments, and promises to reduce levels of health interventions for individuals.

Health care outcomes (along with associated costs and benefits) are a reflection of how well the continuum of care between the primary and community sector and the acute sector works.

The primary health care sector in urban and rural/regional settings can be significantly strengthened through:

- building clinical networks between GPs and specialist services
- the upskilling of local clinicians, especially in areas of high demand, high workforce shortage, and high impact such as endocrinology, cardiology, neurology and paediatrics
- innovative workforce roles, e.g. extended care paramedics, rural medical generalists, and nurses with expanded scope of practice
- better utilisation of local pharmacy expertise e.g. for medication management, triage, and minor ailments, and
- increasing the utilisation of e-health, especially video consultations, to reduce waiting times.

The Tasmanian public health system has responsibility for only part of the primary health sector, and, consequently, has limited influence on GPs and privately practising clinicians. For this reason, linkages to, and partnering with, the Primary Health Network (currently the Tasmanian Medicare Local, or TML) and other community-based health providers will be important.

Community members and consumers are an essential part of producing a better health system and must be given a greater voice in service planning and delivery. Community members are not only demanding to have more say about services, but have the capacity to contribute to their own and others' improved outcomes.

2.4.3 Alternatives to hospital

One of the strategies that will ensure the long term sustainability of our health system is the provision of more care and more complex care in the community.

Already, there are programs and services that help maintain people in their own home and community and future effort will be directed towards expanding this care to include those people who might otherwise today, require hospital treatment.

Rapid response community nursing, hospital avoidance and diversion initiatives and community support for under 65 year old Home and Community Care clients are just some of the ways that Tasmanians can be supported in their own community. Many of these services can be provided from existing facilities such as integrated care centres, community health centres and rural hospitals.

2.4.4 Rural primary health services

Health services in Tasmania's rural and remote communities are predominantly primary health services.

These communities have the poorest health outcomes in Tasmania, generally poorer levels of infrastructure and variable levels of social capital. They are home to some of the state's most vulnerable people; people who will continue to struggle with poor outcomes in an underperforming health system that is focused on high-cost specialist tertiary services.

People in rural and remote areas are often expected to take themselves to specialist clinicians at major hospitals, even though their transport options are, by comparison with urban areas, extremely limited and uncoordinated with health services. This raises important questions of access and equity in the health care system.

In Tasmania's rural and remote communities there are a diverse range of services, typically provided from within a single health facility. This may include collocated GP and ambulance services, inpatient care, residential aged care, emergency care, allied health, maternity care, community nursing, mental health, and health promotion.

Rural facilities also host outreach clinical services which may include medical specialists, child health, pain management teams, and allied health. These facilities are also equipped with video-conferencing technology to assist e-health delivery.

Rural facilities provide a useful model for integrated care, with GPs providing oversight across a continuum of care from home care to rural hospital admission, including referrals and case conferencing with outreach clinicians.

2.5 Working with partners to effect change across the system

To create a truly joined up health system it will be necessary for the THS to partner with a range of agencies to achieve improved patient outcomes.

Partnering between GPs and other clinical providers is important for the sustainability and effective operation of both the primary health and acute health care sectors. GPs in urban or rural locations can provide a range of expanded services when partnered with tertiary-based specialist clinicians and local nursing staff, and supported by e-health technologies (including shared electronic health records). Services include post-operative care and review; rehabilitation; mental health care; hospital avoidance strategies; and chronic pain management.

Interstate partnering will be essential for a range of low volume specialist services such as spinal trauma, complex trauma, paediatric oncology, specialised rehabilitation, and organ transplantation. These partnerships should also build capacity within Tasmania in order to care for patients returning from interstate care.

The Commonwealth Government is a key funder of primary health (especially in rural and remote areas) through the MBS, PBS, and programs such as the Rural Health Outreach Fund and the Rural Primary Health Services Program. It will be important to build greater cooperation and flexibility in the relationships between State and Commonwealth, and to direct resources in a coherent way toward the shared goal of improved health outcomes.

There are three ways to provide access to this specialist care:

- *bring the specialist clinician to the patient*
- *provide the specialist service through advanced technology, and*
- *bring the patient to the specialist service.*

Tasmania provides residential aged care in areas where there is no alternative provider. There is a need to partner effectively with the Commonwealth to meet the demand for aged care in Tasmania, especially for home-based care, in order to avoid increasing demand on ambulance services and acute hospital beds.

The care and commitment to partnerships will be reflected in the quality of the overall health outcomes. Effective change needs committed leadership, long-term cooperation, participation, innovation and critical engagement across all sectors and at all levels.

2.6 Strengthening our transport and accommodation support systems

Many Tasmanians are accustomed to travelling to access health services.

A reformed health service delivery model that is aimed at improving the quality and safety of specialist services may require people from all areas of the state, even those in the major population centres, to travel to access better quality services.

The need to carefully consider the impact on patients, their families and carers has been strongly supported by the submissions in response to the Green Paper.

Interstate experience, where clinically networked services have been in place for many years, has revealed the need for highly integrated, flexible, robust transport and retrieval services.

Accessing care is not always about requiring the patient to travel to the service. There are three ways to provide access to this specialist care:

- bring the specialist clinician to the patient
- provide the specialist service through advanced technology, or
- bring the patient to the specialist service.

The number of specialists travelling to deliver care at another facility within the network is expected to increase. Where these specialists are not available within Tasmania we will look to bring in interstate specialists. This method has proven successful in the past through initiatives such as the Medical Specialist Outreach Program, Rural Health Outreach Fund and the Medical Outreach – Indigenous Chronic Disease Program.

The use of advanced technology presents considerable opportunity to reduce the need for patients to travel. Across the health system there is a range of e-health infrastructure in place, including videoconferencing facilities at 40 sites across the state, comprising many regional and remote medical centres. A range of other telemedicine devices have also been trialled and used for dermatology, obstetrics, renal and mental health clinical consultations. Developing ways to improve access to and utilisation rates of this e-health infrastructure will be an important part of implementing the White Paper decisions.

The Patient Travel Assistance Scheme (PTAS) subsidy rates were increased on 1 July 2014. This scheme will continue to be used to assist patients where they are required to travel. It will be important for the health service to work with their partners in the private and community sector to assess the availability of interstate and intrastate accommodation and, where possible, negotiate rates to reduce the out of pocket expenses incurred by patients.

The Way Forward

Further work on transport and accommodation services can only be completed once a clinical service profile has been completed.

The transfer of patients to and between facilities within the network is and will continue to be critical to the vision of *One Health System*. This will include the requirement for both emergency transport services, including aeromedical resources; medical retrieval; and inter-hospital transfer both to access services not provided locally and in returning a patient for continuing care, where clinically appropriate, by a facility closer to home.

Ambulance Tasmania (AT) provides emergency ambulance services across Tasmania through a network of 53 ambulance stations and five community emergency response teams.

The Aero-medical and Medical Retrieval Service (AMMRS) of AT provides inter-facility transport and mobile critical care for patients requiring movement within and outside Tasmania. AT utilises a range of transport options for aero-medical and medical retrieval activity which includes road ambulances, the fixed wing air ambulance, special operations vehicles and occasionally the Tasmania rescue helicopter. Inter-facility transfers are performed by fixed wing aircraft or by road, depending on resources, weather conditions, destination and patient factors.

Adult and paediatric retrievals are currently performed by the AMMRS with a team based in Launceston, while neonatal and limited paediatric retrievals are performed by the Neonatal Emergency Transport Service (NETS) based in Hobart. The NETS and Paediatric Emergency Transport Service (PETS) services rely on clinical collaboration between AT and the RHH Neonatal and Paediatric Intensive Care Unit (NIPCU).

2.7 Partnerships between the public and private

Public-private partnerships – defined as collaborative arrangements between the public and private health sectors – help us to deliver some services where we have insufficient resources to do it alone, or when duplication of services in both the public and private systems isn't sustainable, or when the private sector can deliver a better service.

When the private system is better able to deliver care than the public system, mechanisms are in place to enable public patients to receive services without out-of-pocket expenses. Alternatively, in some cases, the public system providing this care across public and private sectors makes the most sense.

The medical workforce in Tasmania is highly mobile across the public sector and the private sector, in particular in the hospital sector. This contributes not only to the provision of services and choice for the community but also contributes to the attraction and retention of the medical workforce.

The loss of capacity or limited capacity in one area has inevitable flow on effects on others. For example, the rural hospital sites are dependent on the services of local GPs so a loss of the GP affects the sustainability of the hospital service.

The Women's Adolescents and Children's Clinical Advisory Group (WACS CAG) NETS/PETS Working Group has identified the need to consolidate and formalise arrangements for NETS and PETS to ensure safe, timely retrieval and transfer services for critically ill neonates, children and emergency transport of peri-natal women within Tasmania.

WACS CAG

Co-dependence is inevitable in Tasmania. RACS supports exploration of public private partnerships to ensure access to high quality surgical services. It is important that capacity in the public sector is utilised prior to contracting out services to the private sector. Implications on training surgeons of the future must be considered.

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Recruitment patterns in the public sector influence medical workforce supply in the private sector e.g. preference for full time salaried specialist positions, in particular in the physician specialties. This reliance increases in the North and North West.

The private hospital sector also plays an active role in training in particular at the professional entry and vocational training level. There is an opportunity to build on this role and capacity and in some instance 'share' registrars across sectors to enable there to be a critical mass of activity to support training.

3 Governing the health system of the future

Governance is about leadership and stewardship of the health system. It refers to the structures and processes used to regulate, direct and control the health system.

Good governance is accountable, transparent, responsive to change, equitable and inclusive, effective and efficient and importantly, includes opportunities for stakeholders to play a role in decision-making.

Tasmania, like other jurisdictions, has responsibility for health care services divided between two levels of government. This means that some parts of the health system do not come under the governance of the Tasmanian health system. However, by building a strong governance model for those parts that do there is greater opportunity to effect positive change across the system.

The decisions outlined in this Exposure Draft to define and improve the clinical services across our acute health system will only be effective if they are supported by good governance.

The *Commission on Delivery of Health Services in Tasmania* (the Commission) concluded that clarifying the roles, responsibilities, authorities and accountabilities of Tasmania's health system was an urgent priority.⁷

A well governed health system requires⁸;

- clear specification of roles, responsibilities and accountabilities
- performance monitoring, management and evaluation
- robust clinical governance and quality management systems
- effective corporate management
- effective risk management
- local stakeholder and community engagement, and
- strong leadership and ethics.

That is why the *One Health System* reform process includes a number of initiatives that will implement the significant changes to the way the health system is governed, providing the leadership and structures that will assist the Government's vision for the healthiest population by 2025 to be realised.

These initiatives include:

- The creation of a single THS, in place of the existing three regional THOs.
- A review of the statewide Clinical Governance Framework, assisting us to monitor and ensure the safety and quality of services we provide.
- Improved consultative and clinical leadership arrangements, with the formation of a new HCT which will, among other roles, advise on the appropriate strategic priorities to guide health service planning and delivery in Tasmania. The Health Council will be supported by discipline specific CAGs.

7 Commission on delivery of Health Services in Tasmania- Working towards a sustainable health system for Tasmania.

8 Commission on delivery of Health Services in Tasmania- Working towards a sustainable health system for Tasmania.

- Reviewing and redesigning the role of the DHHS as health system manager and purchaser of services.

Improved transparency about the performance of the health system will drive continuous improvements. This will be supported by the reforms through the development and implementation of Accountability and Performance Management Frameworks, and the development of monitoring and performance indicators to guide and monitor the improvement of our health system.

3.1 Tasmanian Health Service

Tasmania currently has three THOs – THO-North, THO-South and THO-North West – to provide healthcare through the public hospital system and primary and community health services (including mental health and oral health services). The THOs were established as separate legal entities under the Tasmanian Health Organisation Act 2011 and commenced on 1 July 2012. Each THO has its own Governing Council and Chief Executive Officer (CEO).

Evidence to date indicates that having three separate THOs has resulted in sub-optimal outcomes due to duplication of resources and a lack of collaboration between the THOs. Moving to a single THS is expected to address these issues by reducing waste and duplication and enabling the adoption of consistent statewide policies.

As part of the *One Health System* reforms, the three THOs will be merged into a single THS, to commence on 1 July 2015.

- The THS will have a contemporary governance structure, including:
 - a single Governing Council, comprising a chairperson and eight skills-based members with a spread of regional representation
 - a single CEO, supported by local managers to coordinate statewide services at the local level, to focus on getting the best performance from the system as a whole rather than facility by facility, and
 - a single statewide delivery structure, designed to improve the coordination of services and reduce duplication in both administrative overheads and clinical support services.

The creation of the THS will benefit the community by:

- Allowing the adoption of more coordinated statewide strategies, enabling patients to receive the right care, at the right time and in the right place
- Removing duplication of administrative and other support services, freeing up funds which can be redirected to frontline service delivery
- Ensuring that care is provided in locations with the necessary resources to perform procedures safely and efficiently.

Importantly, the single THS will be able to deliver on TCSP and drive decisions about services that are in the best interests of Tasmania as a whole rather than individual facilities or individual clinicians.

3.2 Statewide clinical governance framework

Strong clinical governance is an essential feature of a health system that consistently delivers high quality safe clinical care.

In Australia clinical governance has been defined as “the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care.”⁹

Moving the health system to a single governing and management structure provides the opportunity to improve clinical governance processes and in doing so improve the safety and quality of the health care that is provided.

An example of how this might be operationalised is through the development of a statewide credentialing system. This is the process through which individual clinicians are authorised to work within health services, in particular the scope of services they are able to perform. A single THS means a single credentialing process. This will assist in the mobility of the medical and nursing workforce across hospital sites, enabling practitioners to work and train across multiple sites without having to undertake duplicative processes.

It is timely to review the clinical governance framework as the health system transitions to a single THS.

3.3 Health Council of Tasmania

Good governance includes having local stakeholder and community engagement.

The HCT has been established to provide high-level, representative consultation on the strategic priorities of the health system. The HCT will report directly to the Minister.

There is representation from, and consultation with, operational and governance stakeholders, key professional groups, clinical member representatives, and both consumers and the community to guide planning to ensure that the system is as efficient and effective as possible.

The role of the HCT is to:

- assist the Minister for Health in establishing key strategic priorities for the Tasmanian health system
- contribute to the successful implementation of the *One Health System* reforms
- advise on key clinical, consumer and community issues as raised by the Minister for Health, or identified by the HCT, and
- provide advisory and consultative services to other key stakeholders as appropriate, such as the THS Governing Council, the DHHS and Tasmanian Medicare Local (TML).

9 Australian Council on Healthcare Standards, 2004

The College supports the formation of CAGs. We believe the greatest value is gained from CAGs if they are representative of a broad range of relevant stakeholders. In Tasmania these must have statewide representation and members who are well informed of the issues affecting the whole health sector. The CAGs also need appropriate reporting structures to ensure a feedback loop to/from the government. It is also important the CAGs are careful in providing realistic expectations to stakeholders of what can be achieved.

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3.4 Clinical advisory groups

Clinical Advisory Groups (CAGs) have been established to engage clinicians to provide the expertise and experience for the development of evidence-based advice on clinical statewide issues.

Fourteen CAGs have been established to provide a statewide focus across the whole health care system to inform healthcare provision and lead improvement in service delivery.

Importantly, membership is drawn from across the health professional disciplines and across the regions of Tasmania.

The CAGs have provided vital input into the development of the TRDF and the TCSP through developing evidence-based advice on service distribution and providing an engagement mechanism on decisions around the best distribution of different services and service components across the State.

The CAGs will have an ongoing role in advising on service improvements that will benefit the state as a whole. These will evolve and change over time as health service needs and technology changes.

3.5 Department of Health and Human Services

The overarching role of the DHHS is to exercise its powers as system manager to provide oversight, policy direction and purchasing functions for the Tasmanian health and human services systems on behalf of the Minister for Health and the Minister for Human Services, to ensure that the health and human services systems are being managed safely, effectively and efficiently.

The creation of the THOs on 1 July 2012 resulted in a clear distinction between DHHS, the purchaser of health services and system manager and the THOs as services providers. However, a lack of clarity regarding the authority of DHHS to act as system manager has resulted in uncertainty regarding its power to effectively oversee the public health system.

Clarifying the different functions and accountabilities of DHHS and the THS will enable both organisations to understand their respective roles and embed them in their corporate planning and operations.

The overarching role of DHHS will not change as a result of the *One Health System* reforms. However, as part of the reforms, a comprehensive review of DHHS' structure, function, and organisational characteristics and capabilities is taking place. The aim of the review is to better align DHHS' activities with its functional responsibilities and to clarify the respective the roles of DHHS, the THS and Executive Government.

Clarifying the roles and responsibilities of DHHS will better enable an efficient and accountable health system that:

- purchases the best mix of services for the needs of the State
- delivers services without duplication or waste
- holds decision-makers and service providers accountable for the cost and quality of services provided
- is innovative and flexible enough to adapt to changing circumstances and to meet new challenges, and
- is collaborative across regions and across the primary, secondary and tertiary health sectors.

4 Supporting the health system of the future

There are a number of building blocks which underpin the effective and efficient delivery of health services.

The health workforce is the essential pillar, without which the health service cannot exist. Designing a health system with the interests of the patients at its heart, and maintaining a structure that supports the delivery of safe and sustainable services will attract and retain the health workforce that is needed.

Embedding a research culture and supporting innovation will allow the health system to adapt to the changing health service requirements of the community.

Harnessing the benefits of technology can have a positive impact on the safety and quality of the health services, can provide vital support for health workforce education and development and contribute to providing more accessible services through taking the service to the patient where it is appropriate to do so.

4.1 Workforce: planning, education and training

Like many jurisdictions, Tasmania has had peaks and troughs of workforce supply. The smaller the health service or specialty service, the greater the risk of the service being affected by small changes. For example, the loss of one palliative care nurse in the North West would have a large impact on the ability to provide services.

Health workforce development in Tasmania is currently largely unplanned and driven by operational decision making.

This can lead to services developing in an uncoordinated or unplanned way based on the skills and expertise of existing staff and therefore to unsustainable, single person dependant services.

Training priorities are often based on the health service needs of individual hospitals with few or no links to the broader requirements for medical practitioners for the community as a whole, including the private sector.

A range of key strategies are being progressed through the Strategic Framework for Health Workforce 2013-18 (the Framework) under the following domains:

- Culture of Safety and Quality
- Attraction and Workforce Distribution
- Patient and Consumer Centered
- Access Data and Systems
- Build Capability and Capacity to Work in New Ways
- Leadership
- Efficiency and Flexibility¹⁰

The development of a robust clinical services profile outlined in this paper provides the opportunity to progress this strategy further.

¹⁰ Department of Health and Human Services (2013) *Strategic Framework for Health Workforce* www.dhhs.tas.gov.au

Workforce planning

In 2012, the Australian Government released *Health Workforce 2025 Doctors, Nurses and Midwives*¹¹ providing Australia's first major, long term, national projections. The report demonstrated that without significant changes in workforce design and service delivery models, Australia would not be able to meet the future health care needs of the population. The report suggests that without reforms, Australia will have a shortage of 112 000 nurses and doctors – the majority being nurses (109 000).

The development of an agreed clinical services profile for the major acute hospitals and having a governance system with a statewide focus provides the opportunity to develop the health workforce in a way that is planned and will more closely meet the health service needs of the community.

The health workforce of the future needs to be able to respond to the changing health service requirements of the future. For example, there is the opportunity to provide more care in community settings to create a more efficient and person-centred system. This would need to be matched with a parallel increase in the number or proportion of time that practitioners spend in community settings.

Education and training

Governments, universities, medical colleges and employers are all making individual decisions that influence how many doctors, nurses and allied health professionals are trained. These decisions do not always correspond to an objective to meet the health service needs of the community meaning that some health professional groups are in very poor supply while others are in good supply.

Ensuring training decisions are aligned to what the state needs from health professionals in the future is essential and will be assisted by the development and implementation of a clinical services profile.

By having a *One Health System* approach, there is an opportunity to maximise the training capacity in the system, including through the development of local training pathways for local graduates. In this way, as a state there can be better planning for building the health workforce that is able to deliver the services identified in the TCSP.

Intrastate partnerships can also be enhanced through training partnerships that promote training opportunities between facilities.

Recruitment and retention

Tasmania has a small population that is widely dispersed, in particular in the North West region. This leads to challenges in providing safe and sustainable services across the major hospitals and rural hospital sites.

In addition, having a large range of services with low volumes and single person dependencies creates safety and quality issues which make it difficult to recruit and retain a stable workforce to support those services.

Moving to one THS supported by a TCSP provides a greater opportunity for

Understanding our workforce demographics is essential to achieving system change and developing workforce models and new workforce roles.

Office of the Chief Nurse and Midwifery Officer

11 Health Workforce Australia (2012): *HW2025 Doctors, Nurses and Midwives Volumes 1,2,3*

Endoscopy waiting times are of concern to all governments and screening demands for early detection are increasing. The leading cause of death in Tasmania is cancer of all types and Tasmania has the second highest incidence and mortality rates of Australian states and territories¹⁵. Bowel cancer is the second most common cause of death of males and third most common cause of death of females¹⁶. The adoption of nurse endoscopists could assist in meeting the high demand and waiting times for endoscopy services in Tasmania.

clinicians to work cooperatively with colleagues across campuses, delivering services that are of a complexity that is able to be safely supported in each hospital site. There will also be better linkages with the University of Tasmania providing health professionals greater opportunity to participate in teaching and research. These will have a positive impact on the ability to train, recruit and retain world class health professionals.

4.2 Innovation

Tasmania has a history of innovation however this has not always translated into statewide gains. The capacity to review clinical and organisational evidence and outcomes, and translate that evidence into practice will underpin ongoing innovation in service delivery and workforce development.

Supporting a health system that adapts to changing health service requirements of the community will require a range of new and expanded roles including:

- Work in inter-disciplinary collaborative teams and across the continuum of care¹²
- Provide system wide clinical leadership that extends to team based models of care
- Make better use of technologies to build capacity and improve access to services – this ranges from incorporating the use of equipment into existing practice to the utilisation of new technology for outreach 'virtual clinics' and remote health monitoring and coaching¹³
- Provide specialist rural health services via a generalist range of skills¹⁴
- Make effective use of contemporary teaching and learning technologies
- Provide support to health professionals, enabling the professional to utilise the full scope of their knowledge and skills.

Making better use of our largest health professional workforce - nurses and midwives - has the potential to provide a more efficient overall health service. For example, nurse led clinics have been implemented in a number of Australian states as well as internationally and have been shown to benefit patients through increasing access and decreasing waiting times while providing the best clinical care.

The implementation of *One Health System* provides an opportunity to further explore where there are opportunities to implement workforce and system innovation.

12 World Health Organization (2010) *Framework for Action on Interprofessional Education & Collaborative Practice* http://www.who.int/hrh/nursing_midwifery/en/

13 University Department of Rural Health, Tasmania *Health Informatics* <http://www.utas.edu.au/rural-health/health-informatics>

14 Health Workforce Australia (2013: *National Rural and Remote Workforce Innovation and Reform Strategy*)

15 Australian Institute of Health and Welfare (2012) *Cancer in Australia: An Overview 2012*

16 Menzies Research Institute Tasmania (2010) *Cancer in Tasmanian – A Snap Shot*

4.3 Research

Having a good relationship between health service delivery, teaching and training and research are important for a number of reasons.

Firstly, the provision of quality professional entry education supports the attraction of highly skilled medical practitioners to the State. This is both through the supply of new graduate doctors to the system with experience in Tasmania, and through contributing to the attraction and retention of highly skilled medical practitioners by providing variability in practice with the ability to provide health services, teach and undertake research if desired.

Secondly, having a dispersed model of professional entry training around the state assists in the attraction and retention of academic and research expertise to all the regions of the state.

Finally, having linkages and good relationships between the university sector and health services means that there is an increasing chance that the education of the future generation of medical professionals will be tailored to identified health challenges and priorities. For example, providing more care in community settings for an ageing population with multimorbidities will require medical workforce with experience and expertise in this area.

4.4 Technology

The use of information and communication technology (ICT) can provide a useful adjunct to traditional ways of providing medical services that is typified by the face-to-face, one on one consultation.

The greatest advantage, in the short-term, rests with patients and practitioners located in rural and remote locations.

Telehealth utilised in the right circumstances can minimise patient travel, improve equity of access to health services and provide peer support and advice for medical practitioners working outside of the major metropolitan hospitals.

There is significant amount of telehealth infrastructure right around the state but it is poorly utilised for clinical support purposes. These telehealth facilities are in the four major acute hospitals as well as a number of rural sites.

Other jurisdictions with large rural populations are increasingly using telehealth in emergency departments and have formal relationships with large health services to provide support.

There are a number of barriers to the use of ICT for clinical purposes and include:

- A lack of knowledge in relation to how to use the equipment.
- The telehealth equipment is often concentrated in board and meeting rooms rather than in the clinical areas of the hospitals e.g. emergency departments.
- A lack of operational changes to make the use of telehealth feasible at the clinician level (e.g. scheduling, facilities).

By operating a single health system, the *One Health System* reform process provides the opportunity to harness the existing investment in telehealth to provide better professional support for the medical workforce as well as to provide clinical services to patients.

5 The way forward

The Government is committed to working with clinicians and the community to fix the broken health system. The release of this Exposure Draft allows this conversation to continue and gives the community and clinicians an ongoing opportunity to have input into the process. The Exposure Draft is open for public comment for three months before being finalised and released in June 2015.

Over the next three months the Government will:

- Hold public and staff fora in Burnie, Devonport, Launceston and Hobart in April/May 2015 to continue the community consultation process.
- Conduct targeted consultation with CAGs on the reforms proposed in the TCSP.
- Work with our Chief Nurse and Allied Health Advisor to ensure that the workforce profiles in the TRDF recognise the specialist service workforce requirements of nursing and allied health.
- Meet with key stakeholders to discuss issues raised in the submission process.
- Actively engage with general practice and the primary care sector to identify opportunities for improved utilisation of primary care capacity in the community.
- Work closely with the Australian Government to put in place an agreement to secure funding for the operation of the Mersey, and the services it delivers, into the future.
- Engage with the Health Council of Tasmania on the finalisation of the White Paper.
- Commence development of implementation pathways for the proposed reforms outlined in the White Paper. These will ensure that any preconditions for change are put in place before the clinical services changes occur. This includes making sure that there is an adequate patient transport support network across emergency and non-emergency transport.

The White Paper on *Delivering Safe and Sustainable Clinical Services* will be released in June 2015.

6 More information

For more information on the *One State, One Health System, Better Outcomes* reform package please visit: www.dhhs.tas.gov.au/onehealthsystem

Comments on the Exposure Draft are due 15 May 2015 and can be emailed to: onehealthsystem@dhhs.tas.gov.au

or mailed to:

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Acronyms

ACT	Australian Capital Territory
BMI	Body Mass Index
CAGs	Clinical Advisory Groups
DHHS	Department of Health and Human Services
ED	Emergency Department
GEM	Geriatric Evaluation Management
GP	General Practitioner
HCT	Health Council of Tasmania
HDU	High Dependency Unit
ICU	Intensive Care Unit
LGH	Launceston General Hospital
NSW	New South Wales
NT	Northern Territory
NW	North West
NWRH	North West Regional Hospital
NWPH	North West Private Hospital
PHM	Primary Health Network
QLD	Queensland
RHH	Royal Hobart Hospital
SA	South Australia
TAS	Tasmania
TCSP	Tasmanian Clinical Services Profile
THO	Tasmanian Health Organisation
THS	Tasmanian Health Service
TML	Tasmania Medicare Local
TRDF	Tasmanian Role Delineation Framework
TSSSC	Tasmanian Statewide Surgical Services Committee
VIC	Victoria
WA	Western Australia

Tasmanian Clinical Services Profile

The table below provides the current and future proposed clinical service complexity levels for clinical services at each of the four acute hospitals based on an assessment of current service and specialist workforce requirements and support services available at each site.

	RHH		LGH		NWRH		Mersey	
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
Clinical Support Services								
Anaesthetic Services	6	6	5	5	4	4	3	3
ICU/HDU	6	6	5	5	4	4	Stand-alone HDU	Short stay unit within ED for stabilisation
Pathology	6	6	5	5	5	5	4	4
Pharmacy	6	6	5	5	3	3	3	3
Medical Imaging Services	6	6	5	5	4	4	3	3
Core Clinical Services								
Emergency Medicine	6	6	5	5	4	4	Level 3 capability but some services provided at level 4 and above	3
Trauma Services	5/6	6	5	5	4	4	3	3
General Medicine	6	6	6	6	5	5	Level 4 capability but some services provided at level 5 & 6	4
Integrated Cancer Services								
• Medical Oncology	6	6	6	6	5	5	4	(4)
• Radiation Oncology	6	6	6	6	No level	5	No level	No level
• Haematology	6	6	5	5	4	4	4	4

	RHH		LGH		NWRH		Mersey	
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
Cardiology	6	6	5	5	4	4	3	3
Endocrinology	6	6	4	5	4	4	3	3
Gastroenterology Services	6	6	5	5	4	4	3	3
Infectious Diseases	6	6	4	5	4	4	No level	No level
Hyperbaric medicine	6	6	No level	No level	No level	No level	No level	No level
Neurology	6	6	4	5	3	4	No level	No level
Acute Stroke Services	6	6	5	5	4	4	4	3
Renal Services	6	6	5	5	3	3	2	2
Respiratory Medicine	5	6	4	5	4	4	3	3
Rheumatology and Pain Management	6	6	4	5	No service	4	No level	No level
General Surgery	6	6	5	5	Level 4 capability but some surgery currently performed at levels 5 & 6	4	Level 4 capability but some surgery performed at levels 5 & 6	3
Cardiothoracic Services	6	6	5	5	No level	No level	No level	No level
Ear, Nose and Throat	6	6	5	5	Level 4 capability but some surgery performed at level 5	4	Level 3 capability but some surgery performed at levels 4 & 5	3
Gynaecology Services	6	6	5	5	4	4	Level 3 capability but some surgery performed at level 4	3
Neurosurgery	6	6	5	5	No level	No level	No level	No level
Ophthalmology	6	6	5	5	4	4	4	4
Oral Health Services	5*	5	3	4	3	3	4	4
Orthopaedic Services	6	6	5	5	4	4	3	3

	RHH		LGH		NWRH		Mersey	
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
Plastics and reconstructive surgery	5*	5	5	5	4	4	3	3
Urology Services	6	6	6	6	No level	4	No level	4
Vascular Surgery Services	5*	5	4	4	3	3	No level	2
Neonatology Service	6	6	5	5	4	(4)	3	(4)
Maternity Services	6	6	5	5	4	(4)	4	(4)
Paediatric Medicine	5*	5	4	4	3	3	1	1
Paediatric Surgery	5*	5	4	4	3	3	1	1
Drug and Alcohol Services	5-6	6	4	4	3	3	No level	4
Geriatric Services	6	6	4	5	3	3	No level	4
Mental Health Inpatient Services	6	6	5	5	5	5	3	3
Child and Adolescent Mental Health Acute Inpatient Services	4	5	3	5	3	3	No level	No level
Palliative Care	4***	4**	4	4	4	3	No level	3
Rehabilitation Services	5*	5	5	5	3	3	No level	4

*level 6 services are provided interstate where a service commences at level 5

** Service provided by private provider

*** Palliative Care service level is determined by the National Palliative Care Role Delineation Framework

() = Service level to be confirmed

